			Please T	ype or Print in				•		
			For State Registrar	State of Maryla	-	riment of Healt Fificate of Dea	th	Reg. N	211116	00001
	Physici		1. Decedent's Name (First, Middle, Last)	hton.			M	ate of Death onth Da NUQYY	5 2001	3. Time of Death 12: 50 A M
	Examir		4a. Facility Name (If not institution, give s	treet and number)	enter	4b. City, Town, or Locati		4	County of Death	more
	Funeral Director		5. Social Security Number 6. Sex	V 3 P 1 1	s. last birthday) _ Yrs.		der 24 Hrs. 8. Da	ate of Birth fonth, Day, Year,	9. Birth	nplace (State or Foreign untry)
, \$6°	, »		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Loc	ation	Day	1.41112	A 11.10.	10d. Inside City Limits
	within 72 hours atter death with the Maryland ene. then "natural", or iteme 23e or 28e-f show the Mardical Exercities must be rectified at	Director	MD. Baltim 10e, Street and Number	ore	Gwy	nn Oak		100 0	itizen of What Co	1 ☐ Yes 2 ▼No
	ath with		6716 Alter St.	reet		21207			21.S. A	٩.
9	after de or item	/ Funeral	1 ☐ Never Married 2 ☆ Married	 Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 SNo If Yes, Give 	i	'as Decedent of Hispanic Yes, specify Cuban, Mex □ Yes 2 X No Spec		es or No- , etc.)	14. Race - Amer Black, White Specify: 10 I	
£-0036	72 hours	ted by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	Year or Dates:	16a, Decede	ent's Usual Occupation and of work done during r		16b. F	Kind of Business/	ack
21215	77 77 1	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	o NOT use retired)	nost of working	S	chool	System
and	og a a b ≥	To Be C	17. Father's Name (First, Middle, Last) Payton Reed			18. M	other's Name (Firs	11 17		
Mary	2 should have and have is man	Ě	19a. Informant's Name/Relationship (Typ	1	19b. Mailing	Address (Street and Nu		te Number, City	1	44 4
	ges 1 and t of Health If item 27 or other tr		20a. Method of Disposition 128 Burial 2 Cremation 3 Re		. Place of Dispos cemetery, crem		Treet	5 wy nr	ocation - City or	Md. 2120 Town, State
Baltimore	t. Partmen		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Linease	60		rest Cemeter		le Ou errick C		uneral Home P.
B	Depa Impo any is		23a. Part1. Enter the disease, or complic	sations that caused the de	40	09 Park H	leight. Au	e. Balt	imore, V	. (
	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.	1 lar	Fibrilla	tion	•		Interval Between Onset and Death
il.	/Medical Examiner		resulting in death) Sequentially list conditions, b.	Due to (or as a consi	A .	otic He	eart 1	nsea se		Years
de	uted d anslt	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Byeast		Ler				Years
,09	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a cons						
x 687	ath certificate battending physic	Physician/Medical	IF FEMALE:	Bc. If yes, outcome of preg	inancy					
D. Box	se death of the attention hed for un	sician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3 🔲	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
s, P.O	Attending Physician: The law requires that the death certificate (death.) sctor: After this certificate has been signed by the attending phys the funeral director, page 2 should be detached for use as the	by Phy	Part II. Other significant conditions con	inbuting to death but not r	esulting in the un	derlying cause given in Pa	art I. 2	3e. Did tobacco	use contribute to	the cause of death?
Division of Vital Records,	w require been signature	Completed						1 ☐ Yes 2 4a. Was an		obably 4 Sonknown
al Re	ician: The lav certificate has ector, page 2							autopsy performed? Yes 2 No	prior to death?	topsy findings available completion of cause of
of Vit	hysician: this certifical al director,	To Be	1 103 2 100		DER/Outpatient	3 DOA Other: 4	lace of Death (Che] Nursing Home		6 ☐ Other (Spec	cify)
ion	utending Physideath. ctor: After this the funeral di	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 Yes 2		escribe how inju	ry occurred	
Divis	in Diffic	ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	et, factory, office		ocation (Street a ity or Town, Stat		ral Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Eunerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	ician: To the best of my k er: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the time, date estigation, in my opinion,	and place, and do	ue to the cause(s	s) and manner as id place, and due	stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier			29c. License numb			ate signed (Monti	n, Day, Year)
	3		30. Name and address of person who con	mpleted cause of death (It	em 23a) (Type, F	D564 Old Cour	+18	Jav	mary	5 200b
	Sta	ate	Northwest Hos	otal Center 32. Registrar's Sig	nature 2401	Old Cour	t Road	Kandal	stown	MJJ 21133
DH	Regist		JAN 0 6 2006	John &	Span					
_,		110			ORIGIN	AL				

		Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of	Doutin	2. Date of Deat	eg. No.	
Physic		Eftihia Avgerinos			Month	^{Day} 2006	3. Time of Death 8:00p M
/Media		4a. Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of Deatl		4c. County of De	
		Riverside	Esse	ex		Baltimo	ore
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Yea Months Day		(Month, Day,	Year)	Birthplace (State or Foreign Country)
irector		216-74-1483			2-10-1	921 Gr	reece
T BIT	_	10a. State 10b. County 10c. City, Town MD n/a B	or Location altimore				10d. Inside City Limits
Sa-ra	ecto						1X Yes 2 No
d other than "natural", or items 23a or 28a-1 show event, itts Medical Examinat must be notified at	Funeral Director	359 Cornwall Street	10f. Zip Code 2122			0g. Citizen of What (USA	Country?
ETHI	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cu			14. Race - Ar	merican Indian,
a la	y Fu	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2 X No	1 ☐ Yes 2 ☒ N		o Hican, etc.)	Black, Wi	
SE ES	ed by					16b. Kind of Busines	
Metalls	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occi Give kind of work don life. DO NOT use retii	e during most of wor red)	king	TOD. KING OF BUSINES	ss/moustry
1	Completed	8th	Homemakeı	C		In own h	nome
even	Be	17. Father's Name (First, Middle, Last) Vasilios Kotsatos			ne (First, Middle, M		
	2	19a. Informant's Name/Relationship (Type, Print) daughter 19b.	Mailing Address (Stree		Sarant		Zin Code)
I Treu		Sophia Avgerinos in-law 7	420 Popla	ar Ave.,	Baltim	ore. Mar	yland 212
r orner		20a. Method of Disposition 20b. Place of I	Disposition (Name of crematory or other pi		Date	20c. Location - City	or Town, State
5		1 😾 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Oak1		1/9	/2006	Baltimor	re, MD
ons:		21. Signature of Funeral Service Licensee Marce H. Zannero	22. Name and Add 263 S. 0	ال '	oseph N St. Ba	. Zannin İtimore,	no Jr. FH MD 21224
		23a. Part1. Enter the disease, or conflications that caused the death. Do no shock, or heart failure. List of yone cause on each line.				est,	Approximate Interval Between
an		Immediate Cause (Final disease or condition resulting in death)	L AH	rhyth.	ni as		Onset and Death
er		Due to (or as a consequence of	in du	chythic R	end -	tailure	3-400%
	je.	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events		- 100	1 -	1	
	Examin	Cause, Disease or injury that initiated events c.					
		resulting in death) Last Due to (or as a consequence of):				
	edical	d					
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	205-1			23d. Date of d	delivery
	sicia	1 Yes 2 No	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	cy		Month	Day Year
		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause -	uven in Part I	23a Did to	acco uso contribute	to the cause of death?
	d by	I schowic Condianyopa	hy ,	predimir (AILI).			Probably 4 Dunknown
	Completed	Sub-clavian Dut	Anomi.	0	24a. Was a	n 24b Were	autopsy findings available
	mo		7) •		autops perform	v prior to	o completion of cause of
	BeC	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only on		9\$ 2 <u>=</u> 110
	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 DOA	ther: Nursing H	ome 5 Reside	nce 6 Other (Sp	pecify)
	Certification;	- Cartain Cartaing	ury W	ury at ork? □Yes 2□No	28d. Describe ho	w injury occurred	
	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm			28f. Location (St.	reet and Number or i	Rural Route Number,
	Cert	4 Homicide determined building, etc. (Specify)			City or Town	, State)	
5	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the or investigation, in my	time, date and place opinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
Collibra	Me	29b. Signature and title of certifier M-D	29c. Licer	nse number	7.1	9d. Date signed (Mo.	nth, Day, Year)
		▶ Mts M-D	1	-3875	4	01-04-	2006
		30. Name and address of person who completed cause of death (Item 23a) (T	D Type, Print) EASTE	en Bu	D. M	D-2/2	221.
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature					

ORIGINAL

		•	For State Registrar		State o	f Marylai	nd / Depa			ealth a Death		lental H	ygiene Reg. N	UU	16	00003	
	â.		1. Decedent's Name (First,									2. Date of D	Death Da	v.	Year	3. Time of Death	
	Physici: /Medic	al	Marie E.									Janua			2006		ım
	Examin	er	4a. Facility Name (If not ins	_	_	mber)				Location (of Death			. County			
			2453 Elli 5. Social Security Number	s Roa		7 Age (In vrs	. last birthday)		r 1 Year	II Under	24 Hrs.	8. Date of B		Balt			<i></i>
	Funeral Director		213-34-736	. 10	M 200	88	Yrs.	Months		Hours	Min.	(Month, I	Day, Year,	917	Por	place (State or Foreig ntry) insylvani	 a
			Usual Residence of Decede	nt				1				DCC .		717			
	arylan show	<u>_</u>	10a. State 10b. C	-			ity, Town or Lo									10d. Inside City Limits 1 ☐ Yes 2 XNo	
	8a-f	Director		ltimo	re	Pa	arkvil		-			·	10 0				
	with ti	급	10e. Street and Number	_	-				p Code					tizen of V	vhat Cou	intry?	
	eath of 23	Funeral	2453 Elli 11. Marital Status			edent Ever in I	U.S. 13		2123		igin? (Spe	ecify Yes or I	US		e - Amer	can Indian,	
10	fter d	F	1 Never Married 2		Armed Fo	rces? 2 No		If Yes, sp	ecify Cuba	n, Mexicar	n, Puerto	Rican, etc.)			k, White		
936	al', o	þ	3 Widowed 4 □ Div	orced	If Yes, Gir Year or D	ve ·		1 🗌 Yes	2 2 No	Specify:				Specify	· Wh	ite	
21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "natural", or Iteme 23e or 28e-f ehow event, the Michael Examinar must be mailied at	Completed	15. De (Specify only	edent's Educ			16a. Dece	kind of w	ork done o	durina mos	t of worki	ng	16b. F	(ind of Bu	usiness/li	ndustry	
2	within ene. then	d L	Elementary/Secondary (0		College (1	1-4or 5+)	life.	DO NOT	use retired	1)							
2	Hygien Sthertl		12 17. Father's Name (First, M	iddle (ast)			Home	make	er	18 Moth	ar's Name	(First, Midd		n Ho			
anc	d be filed ntal Hygie ed other	Be										Fere	nchack				
Maryland	2 should be filed within and Mental Hygiene. Is marked other then sumatic event, Ine M.	은	Albert Mi 19a. Informant's Name/Rel		pe, Print)		19b. Maili	ng Addres	s (Street a			il Route Num			State, Zi	p Code)	
	~ ~ ~		Sharon Nie	lsen	Dan	ghter	501	Dor	sev	Aven	ne F	Baltin	nore	_ MI	21	221	
ē,	of Health Item 27 other tr		20a. Method of Disposition		-	20b.	Place of Dispo	sition (Na	ame of	1		Date				own, State	,
Ë	Page nent o nrt: If iry or		1 Surial 2 ☐ Crem. 4 ☐ Donation 5 ☐ Ot		lemoval from	State Be	-				01/0	7/06	Ве	1 A:	ir,	Maryland	i
Baltimore,	permit. Pages 1 a Department of Hes Importent: If Item any injury or othe		21. Signatura Funeral Se	Vise License	Be /	/	2:	2. Name a	and Addres	s ol Facili	ty Cor	nell	yFun	era	LHon	eOfEssex	2
_	20 E # 9		MAN	1108/	OCK	0	3	00 1	Mace	Ave	nue	Balt:	imor	e, I	MD 2	21221	
27			23a. Part1. Enter the disea shock, or heart failure	se, or compli . List only or	ications that one cause on e	eaused the dea	ath. Do not en	ter the mo	de of dyin	g, such as	cardiac o	or respiratory	arrest,			Approximate Interval Between Opset and Death	
1 6	Physician		Immediate Cause (Final disease or condition resulting in death)	- a	E	nd >	stage	7	em)	ent	19					6 MUNT	25
	/Medical Examiner		resulting in death)		Due to	(or as a conse	quence of):									•	
		e.	Sequentially list conditions if any, leading to immediate	t t		(or as a conse	equence of):										_
d	uted d ansit	Examin	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1													
0	be executed sicien and burial-transit	Exa	resulting in death) Last		Due to	(or as a conse	equence ol):										
8760,	cate be executed physicien and the burial-transit	dlcal			d												
9	artifica ing ph e as th	(a)	IF FEMALE:														
Вох	eath certific ettending p for use as	lan/	23b. Was decedent pregna in the past 12 months	nt	1 Live b	tcome of pregr pirth 2 Fe	tal death 3		pregnancy					23d. Dat Mo	te ol deliv nth	ery Day Year	
	the e	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregr 9□ Unkn	nant at time of own	death 5L	Other (specify)				-			,	
P.0	The law requires that the death certifi sie has been signed by the ettending I sage 2 should be detached for use as		Part II. Other significant co	onditions cor	ntributing to d	eath but not re	sulting in the u	nderlying	cause give	en in Part I	l.	23e. Die	d tobacco	use cont	ribute to	the cause of death?	
Records,	uires l signe ld be	d by										10]Yes √2	No	3 🗆 Pro	bably 4 Unknow	n
00	w requir been s	Completed										24a. W	as an	24b. \	Were aut	opsy findings availab	le
Be	The lav	E										au pe 1 ☐ Yes	topsy rformed? 2 No		death?	ompletion of cause of 2 ☐ No	
Vital		a	25. Was case relerred to m	edical						26. Płace	e of Death	(Check only		·	763	2010	
of V	d is	To B	examiner? 1 ☐ Yes 2 ☑ No	F	lospital: 1 ☐	Inpatient 2[☐ ER/Outpatie	nt 3 🗆 🗆	Oth	er: 4□Ni	ursing Ho	me 5 Re	sidence	6 Oth	er (Spec	ty)	
0 _			27. Manner of Death 1 ■Natural 5 □ I	Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o		28c. Injun World	k?		28d. Describ	e how inju	iry occuri	red		
Sio	ten leat tor: the	cat	2 Accident	nvestigation Could not be		-11-1 44	h	М		Yes 2		ORE Leasting	/Ct	4 8/		- LD-ut- Alumbar	
Division	f or Attendation after deati	Certification:	4 Homicide	determined		ing, etc. (Spec	home, farm, st cify)	reet, lacto	лу, опісе				own, Stat		er or mu	al Route Number,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Ce	rtifying Phy	sician: To the	e best of my kr	nowledge, deat	h occurre	d at the tin	ne, date ar	nd place.	and due to th	ne cause(s	and ma	nner as	stated.	
	n 24 h	edical	(Check only 2 Me	dical Exami	ner: On the b	asis of examir ner stated.	nation and/or in	vestigation	n, in my o	pinion, dea	ath occurr	ed at the tim	e, date an	d place,	and due	to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of	certifier	:			2	9c. Licens	e number			29d. Da	ate signe	d (Month	Day, Year)	
) Uhu	Ks (, حطر	$M \cdot D$	•		D90	619	07		D	110	5/0)6	
	4		30. Name and address of p	erson who co	ompleted cau	se of death (Ite	em 23a) (Type,	Print)	A . = :			, 17		00 -	-	WD 0	
	V		Chukwur	na El	00,	ITI.D		4 N	14 Ce	- AV	1411	le, 13	wit 7	(11)	re,	MD 2122	1
45	Sta Registi		31. Date filed (Month, Day,		32. 6	egistrar's Sigi	and and	· 26	2								

DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of Maryla		artment of H rtificate of I		_	giene Reg. No	006	00004
I	Physici /Medic		1. Decedent's Name (First, Middle, Last) GAIL	ARI	UNG	ON		2. Date of De Month	Day	1 2 COL	3. Time of Death
	Examin Funeral Director		4a. Facility Name (If not institution, give st Nonth WEST (15) 5. Social Security Number (6. Sex 217-50-4718	spital	rs. last birthday) Yrs.	4b. City, Town, or RAACUS	Location of Death If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	4c. C	Coun	lace (State or Foreign
	ט		Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo	ocation		10 1	T 1)7		0d. Inside City Limits
	Maryin	tor	MD BALTIMOR		RANDAL					'	1 ☐ Yes 2 No
	or 284	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citize	on of What Coun	itry?
	eath w	eral	3708 CASSEN ROAD	2. Was Decedent Ever in	118 12	211				SA Bass America	and the state of
21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hyglene. Important: if item 27 is marked other than "neturel", or itame 23a or 28a-f show any fijury or other treumatic event, the Medical Examinal must be notified at 9DCs.	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes XXNo	spanic Origin? (Spe n, Mexican, Puerto I Specify:	Rican, etc.)		Black, White, becify:	etc.
15-0	"netu	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of working	g	16b. Kind	of Business/Inc	dustry
212	d within	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		CKER/SUPE			Bl	ERACON	
pu	be file tal Hyg d othe event,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name			umame)	
Maryland	hould d Men marka matic	₽ P	Jonathan 19a. Informant's Name/Relationship (Typ)	Ausby	19h Maili	na Address (Streets	Rebie	Peter		Town State 7in	Codel
Ma	and 2 s alth ar 127 io		JOHN ARRINGTON, JR				ROAD, RANI				
Baltimore,	Peges 1 ament of He mant: If item lury or other		20a. Method of Disposition 1) ■ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	KING MEI	natory or other plac MORIAL PK	01-07,	1	BALTO	tion - City or To	
Ball	Depart Import any in		21. Signature of Funeral Service Licenses	Mart			s of Facility JAM URENS ST.		MORTOI IMORE		F.H.,INC 1217
	Physician		23a. Part/. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused the decause on each line.						, MD 21	Approximate Interval Between Onset and Death
*	/Medical Examiner		disease or condition resulting in death)	Due to (or as a cons	sequence of):	work	mfar	any.			
	D ∺	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e to (er as a cons	sequence of):	y					
•	ficate be executed physicien and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):	Virline				-	
58760,	ysicier	cal E	d.								
. Box	death certi e attending id for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₱No 9 □ Unknown	c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			230	d. Date of delive Month	ry Day Year
	uires thet to signed by lid be deter		Part II. Other significant conditions control Dibotes Me	ibuting to death but not r	resulting in the u	nderlying cause give	n in Part I.		obacco use Yes 2 □ I		e cause of death?
Division of Vital Records,	Physicien: The law requires that the this certificate has been signed by the rail director, page 2 should be deteched.	Completed						24a. Was autop perio Yes	osy ormed?	prior to con death?	psy findings available repletion of cause of
Vita	icien: certific rector,	Be	25. Was case referred to medical examiner?	spital:		Otho	26. Place of Death	Check only o	one)		1
ō	Phys er this eral di	n: To	1 ☐ Yes 2 ♠ No 27. Magner of Death	28a. Late of Injury	☐ ER/Outpatier 28b. Time o		4 Nursing Hom	e 5 🗌 Resid)
sion	Attending ir deeth. ector: After by the fune	atio	1 Natural 5 Pending investigation	(Month, Day Year)	Injury		? ′es 2 □ No				
DÍVÍS	To the Hospital or Attending Physicien: The law within 24 hours after deeth. To the Funaral Director, After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	ecify)			City or Tox	vn, State)	Number or Rural	
	To the Hospital or within 24 hours after to the Funaral Dir completely filled in	Medical	one)	cian: To the best of my ker: On the basis of exami and manner stated.	knowledge, deatl ination and/or in	vestigation, in my op	inion, death occurre	d at the time,	date and pl	ace, and due to	the cause(s)
	5.₹ £ §		29b. Signature and title of certifier	la	4.4	29c. License	2977		290. Date s	signed (Month, E	Day, Year)
2	,		30. Name and address o erson who com	pleted cause of death (II	tem 23a) (Type,	Print)	0		Bluch	m 12	000
	Cu		31. Date filed (Month, Day, Year)	32. Registrar's Big	try Der	ve, Cilen	burno	· W.	١.	21061.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 0445 M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University Speciality Hospital Baltimore City N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Yea 3/2/1929 Birthplace (State or Foreign Country) **Funeral** Vear 216-22-3771 1**⊘**M 2□ F 76 Yrs. Director VA Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at MD Anne Arundel Brooklyn Park, MD 1 Yes 2000 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 Bon Air Avenue 21225 United States or items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2204\lo If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married white 1 Yes 2 No Specify: Specify. 3√2√Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than eny injury or other traumatic event, If a Mar Elementary/Secondary (0-12) College (1-4or 5+) Steel Fabricator Metal Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Alvis Rosa Woodcock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles D. Alvis / Son 7810 Renshaw Road, Pasadena Maryland 2122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 1/05/2005 Baltimore Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Victor P. Doda Charles L. 1501 East Stevens Funeral Home, Inc. Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Physician antery disease /Medical Due to (or as a consequence of): **Examiner** erebro vasenda Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine transit. allerse Due to (or as a consequence of): the burial-Box 68760. physician Seizures Physician/Medical esn IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) P.O. 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performer 2 No 2 No 1 Yes 1 Yes 25. Was case reterred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred al or Attending P s after death. Il Director: After I 1 Natural 5 Pending Injury 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral E Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D34974 Anolita un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARU MEHTA, MD, 611, South Charles Street, Beltimore MD 21230

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

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	deetl	ner	11. Marital Status 1	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent	of Hispanic Or Cuban, Mexica	igin? (Speci	ify Yes or No-			an Indian,
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P	al Hy d othe	Bec	17. Father's Name (First, Middle, Last)	_					First, Middle, Ma)	
Maryland	Ment Ment Marked	P _L	William M. Bennett						Meisenha			
Mar	12 sh h and 7 ts rr traurr		19a. Informant's Name/Relationship (Typ						Route Number, (Itimore,			Code)
	1 and Healt am 2	3	Ms. Carol L. Cordi		Place of Dispo	sition (Name o	f !	Dai		c. Location - 0		wn State
lon I	ages ant of it: if it y or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	сөтөtөгу, сгөг Ilaney V	natory or other	place)	-10-0		imoniu		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Department of Health and Mental Hygiene. Important: if Itam 27 is marked other then "natural", or Itame 23a or 28a-1 ehow any injury or other traumatic event, the Medical Expointer must be multiple and once.		21. Signature of Fymerall Service License			. Name and Ad	dress of Facili	ity			1115 171	u.
m	Depar Depar Impor any ir		1 Chity	8		Ruck To	owson F	unera	l Home, on,Md. 2	Inc.		
*	14.5		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the de	ath. Do not ent	er the mode of	dying, such as	cardiac or	respiratory arres	.1204 t,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Chroni	c Ky	enal	Fail	ure				Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conse		0	1 1	11		11)		
		1	Sequentially list conditions, b.	Due to (or as a conse	- QQ	ende	nt di	abet	62 W.	ellitu	2	years
0	uted i insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 10 (01 40 4 001)50	squarica or).							
Ć,	exection and and rial-tra	Еха	that initiated events c. resulting in death) Last	Due to (or as a conse	equence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai	L d.									
9	ertifica ling pl	Med	IF FEMALE:									
Вох	leath certific attending p	Physician/Me	in the past 12 months?	 c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 	tal death 3	Ectopic pregna				23d. Date Mon		nry Day Year
o.	that the de led by the a detached t	yslc	1 ☐ Yes 2区 No 9 ☐ Unknown	9 Unknown	death 5	Other (specify	/)					
<u>α</u>	res that igned b be deta	by Pt	Part II. Other significant conditions cont	ributing to death but not re	sulting in the ur	nderlying cause	given in Part I	l.	23e. Did toba	cco use contri	oute Io th	e cause of death?
rds	w requires been sig should be	ed b							1 🗆 Yes	2.2 No	B 🗌 Prob	ably 4 Dunknown
Records,	taw re as bee 2 sho	piet							24a. Was an	24b. W	ere auto	psy findings available
E E	sician: The law certificate has t irector, page 2 s	Completed							autopsy performe	d? de	ath?	npletion of cause of
Vital	nding Physician: th. : After this certifica funeral director, p	Be (25. Was case referred to medical examiner?			73725	26. Place	e of Death (Check only one)			
of	Physi this c	5 1	1 Yes 2 No		☐ ER/Outpatien				5 Residence			/)
U	ding h. After funer	tion	1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Work? 1 □ Yes 2 □		d. Describe how	injury occurre	d	
Division of	al or Attendi after death. Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, stre				f. Location (Stree	et and Numbe	or Rura	l Route Number.
Ö	al or s after il Dire	Serti	4 Homicide determined	building, etc. (Spec	cify)	,,,			City or Town,	State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine	cian: To the best of my ki	nowledge, death	occurred at th	e time, date an	nd place, an	d due to the cau	se(s) and man	ner as st	ated.
	the H hin 24 the F nplete	Medical	Une)	and manner stated.	ation and in			in accurred				
	To with	-	29b. Signature and title of certifier	1,0.14	1111	29c, Lic	ense number	140	290	. Date signed		04.
	, VI		I westing	1 mid Mi	14/17		, , , ,	()		Janu	ary	04, 500P
	107		30. Name and address of person who con				DOAD	mt Maar	T1774 245	27002		
	Sta	te	ERNESTINE WRIGHT, 1 31. Date filed (Month, Day, Year)	32 Registrar's Sign	OULANEY nature		KUAD	I I MON	IUM, MD	21093		
	Registr		JAN 0 6 2001	Eliteras 1	G Again	alles						

DHMH 17 Rev 1/2001

JANUARY 4, 2006

WILLIAM BENNETT

			1 - For State of Maryl	land / Department of Health and Mental Hygiene Certificate of Death	006 00009
**	Physici		1. Decedent's Name (First, Middle, Last) , A 14 DA	Bennett 2. Date of Death Month Pay 18	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Mary Iana Greneral He	Ospital Baltimore City	County of Death
	Funeral Director	4	5. Social Security Number 3/6-32-7747 G. Sex 1□ M 2 XF 7. Age (In 1□ M 2 XF	yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Month, Day, Year)	9. Birthplace (State or Foreign Country) 28 Maryland
	Maryland I-f ehow	tor		c. City, Town or Location Paltemare	10d. Inside City Limits
	h with the 23a or 28a III be not	Funeral Director	10e. Street and Number 22 South Athol	St. 10f. Zip Code 10g. Citize 21229	en of What Country?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at	Ď	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	4. Race - American Indian, Black, White, etc. Specify: Black
21215-0	filed within 72 ho Hygiene. Ahor than "natui ant, ins Madical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	d of Business/Industry
and	should be filed nd Mental Hygi i marked other umatic event,	To Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden S Blannie Park	sumame) Rev
, Maryl	1 end 2 sho Health and Iom 27 is mu		19a. Informant's Name/Relationship (Type, Print) Bonita B. Barrett-day	19b. Mailing Address (Street and Number or Rural Route Number, City or 4415 Kirkwod Rd. Bacto, ma	
altimore	a		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Ob. Place of Disposition (Name of cometery, crematory or other place) Ling mem. Park 1/07/06 Ren	daels form, md.
Balti	permit. Page Department of Important: if eny injury or once.		21. Signature Funeral Service ic	Cany Primarch Reneral Home	a Bacto, md. 21229
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate cause (Final disease of condition resulting in death) a. Due to (or as a condition resulting in death)	death. Do not enter the mode of dying, such as cardiac or respiratory arrest, P	Approximate Interval Between Onset and Death
8760,	be executed cian and burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cond	insequence of):	
P.O. Box 68	The law requires that the death certificate tie has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 moeths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 Ectopic pregnancy	3d. Date of delivery Month Day Year
	w requires that s been signed b should be deta		Part II. Other significant conditions contributing to death but no End Stage Kenal Disc	ot resulting in the underlying cause given in Part I. 23e. Did tobacco us Past on Hemodialy51'S 1 Yes 2	se contribute to the cause of death?
of Vital Records,	The law reate has bee page 2 sho	Completed by	Concestrue Heart Parlure	2- With Pacemaker, 24a. Was an autopsy performed? 2- Burass 1 yes 2 lighton	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
f Vita	Physician: this certific ral director,	To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6	□Other (Specify)
Division o	ding After fune	ation:	27. Manner of Death 1 Natural 5 Pending (Month, Day Yei 2 Accident Investigation	ar) 28b. Time of Injury Mork? 28c. Injury at Work? 1 Yes 2 No	occurred
Divis	rs after de al Directo ed in by t	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (S	At home, farm, street, factory, office 28f. Location (Street and City or Town, State)	l Number or Rural Route Number,
	To the Hospital or Attant within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner stated.	y knowledge, death occurred at the time, date and place, and due to the cause(s) a amination and/or investigation, in my opinion, death occurred at the time, date and p	and manner as stated. place, and due to the cause(s)
	with To	Σ	29b. Signature and title of certifier \$\int DR \cdot CHANCE \$\int	00-27 1/	e signed (Month. Day, Year) 3/06
	5		30. Name and address of person who completed cause of death (Nan Chall Proph, M.D.	(Item 23a) (Type, Print) A Yo Mary and General Hi	ospital
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's S	Signature Sparks	

			1- For State of Maryland / Department of Health and Me Certificate of Death	ental Hygien	
	Physicia /Medic Examin	al	Mary A Bumpass	Date of Death Month Decuration	ay Year 3. Time of Death 1055 PM c. County of Death Baltmore
ł	Funeral Director	ú	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8	Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country) 923 North Carolina
	Be-f ehow	ector	10a. State 10b. County NA 10c. City, Town or Location Batternure	J	10d. Inside City Limits 1 ∑ 2 □ No
	death with ti ms 23a or 2	Funeral Director	10e. Street and Number 1801 went worth Rd. 2/234 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specifity Yes, specify Cuban, Mexican, Puerto Richard Forces)		14. Race - American Indian,
9000	d within 72 hours after death with the Maryland jiene. Ithe Macheal Examiner must be notified at the Macheal Examiner must be notified at	þ	3 Widowed 4 □ Divorced Year or Dates:		Black, White, etc. Specify: Black
21215-0036	d within giene. or then "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secopdary (0-12) College (1-4or 5+) A CR (1-40 R)	7	Kind of Business/Industry Battimore Cty
Maryland	be fi	To Be (17. Father's Name (First, Middle, Last) Te SSE O, Royster Sadu	2 00	Kley
-	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		20a. Method of Disposition 20b. Place of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date	pt B4	or lown, State, Zip Code) c. md, 2i 206 cocation - City or Town, State
Baltimore	permit. Pages Department of Importent: If i any injury or one		1 Surial 2 Cremation 3 Removal from State 4 Donation 3 Other (Specify) 21. Signature of Juneral Servic Licenses 22. Name and Address of Facility	HILTON	Pass nd.
			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock or heart failure. List only one cause on each line.	eneral H	Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death) a		
8760,	sate be executed physician and the burial-transit	Ical Examiner			
P.O. Box 687	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Medic			23d. Date of delivery Month Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Records,	The ate h	e Completed	***	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Z Z		0 8	examiner? Hospital: 1 Innatient 2 FR/Outnatient 3 DOA Other: 4 Y Nursing Home		6 ☐Other (Specify)
n of	ng Phys fter this neral di	Ju: T		d. Describe how inju	
Division	To the Hospital or Attending Is within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	Z	f. Location (Street a City or Town, Stat	and Number or Rural Route Number, (e)
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred	at the time, date ar	nd place, and due to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier 29c. License number D0059423	29d. Di	ate signed (Month, Day, Year)
	J Sta	te_	and manner stated. 29b. Signature and title of certifier 29c. License number DOSS423 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) DOSS423 31. Date filed (Month, Day, Year) 32. Registrar's Signature	3 Bultu	Dre, MD 21239
	Registr		JAN 0 6 2006 Jan & Spark		

Karen Beck 06-0065 dl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Stete Registrar	State	of Maryla		artment of He rtificate of D		Mental H	ygien Reg. N	CUU	00011
	Dhuniai		1. Decedent's Name (First, Middle						2. Date of I		av Ye	3. Time of Death
	Physici /Medic				Marie	Beck			Janua	ry 3	2006	1:39A M
	Examin	er	4a. Facility Name (If not institution		umber)		4b. City, Town, or L Baltimore		ith	4	c. County of D	
	Funeral		Harbor Hospita. 5. Social Security Number	L 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hr		Birth	9	Birthplace (State or Foreign
	Director		217 62 9214	1 □ M 2 🕱 F	53	Yrs.	Months Days	Hours Mir	Nov •	лау, төа [7, та	1952	Maryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	ocation					10d. Inside City Limits
	Mary I eho	ţo	Maryland 1	N/A		Baltimo	re					1. Yes 2 □ No
	th the	Director	10e. Street and Number		I		10f. Zip Code			10g. C	Citizen of What	t Country?
	ath wi	rai	1425 Filbert				2122			L	U.S.	
	within 72 hours efter death with the Maryland ene. than "netural", or Items 23s or 28s-f ehow he Medical Examination invited at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed F	cedent Ever in Forces? : 2 📉 No		Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (, Mexican, Pue	Specify Yes or I rto Rican, etc.)	No-		American Indian, Vhite, etc.
9	ral', or	þ	3 XWidowed 4 ☐ Divorced	If Yes. G	Sive		1□Yes 25 No	Specify:			Specify: W	White
5	72 hc	etec	15. Deceden (Specify only highe	t's Education st grade completed	i)	16a. Dece	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of we	orking	16b.	Kind of Busine	ess/Industry
12	within ene. then	Completed	Elementary/Secondary (0-12) 12th	College	(1-4or 5+)		ekeeper				Holid	lay Inn
<u>ğ</u>	be filed stal Hygid of other event,	Be C	17. Father's Name (First, Middle,			1	1		ame (First, Midd			
ylar	should by	70 8	Gil	bert Fra	nklin E				h Kohol:			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours efter death with the Marylan if Health and Mental Hygiens. Item 27 Ie marked other than "netural", or Items 23a or 28a-1 ehow other traumatic event, Inc. Medical Examinar inselfer inclined at		19a. Informant's Name/Relations Sharon Elliott		r		ng Address <i>(Street an</i> 1bot Stree		altimor			
altimore,	of Hei		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 DRamoval from	20b	. Place of Dispo cemetery, crei	esition (Name of matory or other place)	1	Date	20c.	Location - City	or Town, State
Ē	t. Pages tment of I tant: If It		4 Donation 5 Other (S	pecify)			ll Cemeter		/2006			, Maryland
Ba	permit. Pages Depertment of Important: If It eny Injury or o		21. Signature of Funeral Service	Znomu	oul		2. Name and Address 2001 Ritchi					ice, P.A. ryland 21225
			23a. Part1. Enter the disease of shock, or heart failure. List	complications that only one cause on	caused the de each line.	eath. Do not ent	er the mode of dying,	such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
¥	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		OWAR		OMBOEHS	OLISM				Sings and Basin
	Examiner		Sagraptially list and disease				ZIZORMOSIS	COMPL	CATING	_		
/	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated cause)	Due to	o (or as a cons	equence of):	LECENT SUR	GICAL W	NEE RE	PLAC	EMENT	
	execut n and al-trar	Examin	that initiated events resulting in death) Last	c	o (or as a cons	equence of):					-	
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	ertifica ding pt	Med	IF FEMALE:	00- H								
.O. Box	es that the death certifigned by the ettending be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pred birth 2 DF gnant at time o	etal death 3	Ectopic pregnancy Other (specify)				23d. Date of Month	delivery Day Year
ö	by the tached	hysi	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□ Unk								
S, P	res tha signed I be de	2	Part II. Other significant condition			-	nderlying cause given	in Part I.				e to the cause of death?
Š	w require	eted	LU905 CP	THEMA	1850	>			24a, W	Yes :		Probably 4 Donknown
ž	The law cate hes to page 2 s	Completed							au pe	opsy formed?	death	autopsy findings available to completion of cause of n? (es 2 \(\text{No} \)
<u>I</u>	cien: ertifice	BeC	25. Was case referred to medica examiner?						eath (Check only			20110
5	Physic this o	٩	1 Yes 2 □ No 27. Manner of Death			ER/Outpatier		4 L INGISHIG	Home 5 Re			Specify)
o	iding Physicien; th. After this certifics funeral director,	tion	1 Natural 5 Pendir 2 Accident investi	g (Mo	e of Injury onth, Day Year,	28b. Time of Injury	Work?	s 2∐No	28d. Describ	now inj	ury occurred	
Division of Vital Records,	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funarel Director: After this certificate hes been signed by the eltending a completely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	ce of Injury - Alding, etc. (Spe	t home, farm, str ocify)	eet, factory, office			(Street a		Rural Route Number,
	Hospital or All 24 hours after of Funarel Direction by letely filled in by		29a. Certifier 1 ☐ Certifyir	g Physicien: To th	ne best of my	nowledge death	n occurred at the time	date and place	e and due to th	e causo/	s) and manner	r as stated
	To the Hospital or At within 24 hours after o To the Funarel Direct completely filled in by	ledicai	(Check only 2) Medical one)	Exeminer: On the and ma	basis of examinner stated.	ination and/or in	vestigation, in my opir	nion, death occ	curred at the time	e, date ar	nd place, and	due to the cause(s)
	To with	Σ	29b. Signature and title of certifie	5 -			29c. License r	number				onth, Day, Year)
	10		30. Name and address of person	who completed car	use of death /l	tem 23a) (Tvne	OCME Print)			Janu	uary 3,	2006
	Y		ANA	RUBIC) , M	10	111 Penn	Street	, Baltin	ore,	Maryl	and 21201
	Sta Registr		31. Date filed (Month, Day, Year)	324	Registrar's Sig	gnature	and I		-			
	Togioti		JAN U	1 LUUU JA	Co Capaciana	9	*					

	•	1	For State Registrar	1 10000	State of N	laryland	-		t of H	ealth a		_	_	6 000	12
	ysicia: Medica	n ,	Decedent's Name		own.							2. Date of De Month	05 2 F		
Ex	kamine	r 4		51 /	ve street and number	CENT Age (In yrs. las	EK t birthday)	BA	112	Location of	;	8. Date of Big		f Death TIMORE 9. Birthplace (State or	Foreign
Dire	ector	6	2/3-/4- Jsual Residence of [3314	1 X M 2□F	82	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da APKIL C	ay, Year) 23, 1923	Country)	
e Maryland	ilied at		Md.	10b. County BAL	TIMORE	10c. City, 1		ocation ORE						10d. Inside City	
th with the	on ad Isu	5	10e. Street and Num	ber THREE	Onks	•		10f. Zip	21	208			10g. Citizen of Wi	5A	
0036 hours efter death with the Maryland turel', or Items 23e or 28e-f show	E .	by Fur	11. Marital Status 1 Never Marrie 3 Widowed 4	•	12. Was Deceder Armed Force: 1 XYes 2 [If Yes, Give Year or Dates	3?		Was Deced If Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe , Puerto i	cify Yes or No Rican, etc.)		- American Indian, White, etc.	
within 72 ene.	he Medical	Completed	(Specification (Speci	dary (0-12)	Education rade completed) College (1-40	r 5+)	(Give life.	dent's Usua kind of wor DO NOT us	rk done d se retired	luring most		ng	16b. Kind of Bus	iness/Industry	26.S
Maryland 2 Id 2 should be filed Ith and Mental Hygi 87 Is marked other	• ٧ • ١	To Be Co	17. Father's Name (F	First, Middle, Las			<u> </u>	<i>,</i>			r's Name		, Maiden Sumame)	
a and a	Ē	•	ERMA C	me/Relationship	(Type, Print) SPOUSE	-	4710	THE	EE	ank		44		tate, Zip Code) 21208 City or Town, State	
Baltimore Sermit. Pages 1 Department of He			20a. Method of Dispo 1 Burial 2 □ 4 □Donation : 21. Signature of Fun	Cremation 3 l		e GAR,	RISO	osition (Name and 2). Name and	d Addres	I/A	BE	USRIY	OWINGS D. Cron	MILLS I	15
	E 6		23a. Part Enter the shock, or hear	e disease, or con failure. List on	mplications that caus y one cause on each	ed the death. line.	Do not en	945 ter the mod						Approximate Interval Betwo	een
Priysi /Med Exam	dical	1	Immediate Cause (F disease or condition resulting in death)		Due to (or a	as a conseque	nce of):			P515			s= .c		3411
760, te be executed ssiclen and	e burial-transit	E I	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or in that initiated events resulting in death) Li	lying njury	b. E TER Des to (or a	as a consequen	PIC-	IF AI			I V	MEC	11011		
Box 68 death certifica		Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?		2 Fetal di at time of dear	eath 3	⊒Ectopic pr ⊒ Other (sp		5			23d. Date Mont	of delivery th Day Ye	ear
rds, P quires thet	9 9	۵	Part II. Other signifi	cant conditions	contributing to death	but not resulti	ing in the u	ınderlying c	ause givi	en in Part I.			_	oute to the cause of de	eath? nknown
Re la	page 2	Completed		2,5 ,53,74								24a. Was auto perf 1 Yes	opsy pr ormed? de	ere autopsy findings a for to completion of ca eath? Yes 257 No	vailable use of
of Vital F Physician: Th	2 5	To Be	25. Was case referrence examiner? 1 Yes 2 X	No	Hospital: 1 Minpa		₹/Outpatie		-	er: 4 🗆 Nu	ırsing Ho		idence 6 Other		
sion c anding P auth.		Certification;	27. Manner of Death 1 Natural 2 Accident	5 Pending investigate		njury 2 Da <i>y Year)</i>	8b. Time o Injury	of 2	8c. Injun Worl	yat k? Yes 2□		28d. Describe	how injury occurre	d	
Division let or Attending s after death.	ed in by t	Certific	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	200. Flace U	Injury - At hom etc. (Specily)	e, farm, st	reet, factory	, office				(Street and Numbe own, State)	r or Rural Route Numb)9r,
Division To the Hospitel or Attending within 24 hours after death.	completely filled in by the funeral	Medical	29a. Certifier (Check only one)		Physician: To the be aminer: On the basis and manner	of examinatio		rvestigation	, in my o	pinion, dea			, date and place, a	nd due to the cause(s)	
Tot	шоо	Σ	29b. Signature and	title of certifier	Mehla	M.D			Ph	e number			January	(Month, Day, Year)	6-
7+			30. Name and address	ss of person wh	o completed cause of	CENTE	R	Print)		NDE		MEH	717	3	
R	Sta legistra		31. Date filed (Mont	AN 0 6	1	strar's Signatu	re K	Coule	,						

	i ioaso i	State of Manuar			nd Montal Hya	iono	
	1 - For State Registrar	State of Marylan	•	te of Death		eg. No. 006	00013
	Decedent's Name (First, Middle, Last)			Λ	2. Date of Deat	-	3. Time of Death
Physician /Medical	Joseph			DROWN	January	3 2006	00:49 AM
Examiner	4a. Facility Name (If not institution, give s	. 1	4b. City	, Town, or Location of	Death	4c. County of Dea	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) If Under	TYear If Under 24	Hrs. 8. Date of Birth		thplace (State or Foreign
Director	220-07-1339 A	M 2□F 8:	1 Yrs. Months	Days Hours	Min. 8. Date of Birth (Month, Day, 8/23/19	924 MAI	RYLAND
land ow	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Limits
Mary e-f eh	MD. BALTIMOR	RE	DUNDA	LK			1 Yes 2 No
with the Mar. s or 28e-f et be notified Director	10e. Street and Number 3432 CORNWALL ROAI)	10f. Z	ip Code 21222		0g. Citizen of What Co JNITED STAT	· ·
S ofter death v ritems 23s rites must	11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was Dec		n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame	erican Indian,
5-0036 72 hours efter death with the Maryland neturel; or items 23a or 28a-1 show dical Examinat must be notified at eted by Funeral Director	1 ☐ Never Married 2 💥 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	If Yes, sp		Puerto Rican, etc.)	Black, Whi	te, etc. HITE
21215-0036 ad within 72 hours eff advition "neturel", or er then "neturel", or it the Mudical Exam. Completed by F		cation	16a. Decedent's Us	ual Occupation ork done during most of	of working	16b. Kind of Business	/Industry
21215-0 ed within 72 ho ygiene. ner then "netur it, the Mudicall	Elementary/Secondary (0-12)	College (1-4or 5+)	TRUCK DI	use retired)		TRUCKI	NG.
be filed tal Hygie d other test.			TROCK DI		s Name (First, Middle, i		,,,,
ylan ould be I Mental Marked o watic eve	ADAM F. BROWN			CATH	ERINE WOIZ		
Maryland Id 2 should be flight and Mental Hy 27 is marked oth traumatic event	19a. Informant's Name/Relationship (Ty. JULIE BROWN/WIFE	pe, Print)			or Rural Route Number , BALTIMORE		
	20a. Method of Disposition	20b. I	Place of Disposition (No	ame of	-	20c. Location - City or	
0 0 2 2 2	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	rro cremato γ		/4/06 I	BALTIMORE,	MARYLAND
Baltimore, pernit. Pages 1 a pernit. Pages 1 a la la la la la la la la la la la la l	21. Signature of Fiveral Service License	A	6224	EASTERN AV	CHARLES S. E., BALTIMO	DRE, MARYLA	•
	23a. Part1 Enter the disease, or complete hock, or heart failure. List only or	cations that caused the deal	th. Do not enter the mo	ode of dying, such as co	ardiac or respiratory arr	est,	Approximate Interval Between
Physician	Immediate Cause (Final disease or condition resulting in death)	CALDIOLEMIC	- 11 1.				Onset and Death 24 hours
/Medical Examiner		Due to (or as a consec	quence of):	L'a.			al bour
Le contraction de la contracti	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):	1071			J. 1. Vola-5
760, be executed sicien and burial-transit	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):	1 41			
760 e be sicie e bur	L.	i					
		. 336					
P.O. Box 68 nat the death certifice d by the ettending pt etached for use as the physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	al death 3 Ectopic			23d. Date of de Month	elivery Day Year
that the death that the death edby the etter detached for y Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	30000				
b ed bed	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the underlying	cause given in Part I.		bacco use contribute t	
w requir							robably 4 2 Unknown
If Records, The law requires to cate has been signe, page 2 should be completed by					24a. Was a autops perfor	medy prior to death?	utopsy findings available completion of cause of
	25. Was case referred to medical			26. Place	1 ☐ Yes of Death (Check only or		s 2□No
A SEE	1 Yes 2 No	_	ER/Outpatient 3 ☐ t		sing Home 5 Resid		ecify)
ding F ding F h. After funera	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ N		ow injury occurred	
Division for Attending after death. Director: After Jin by the fune	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At h building, etc. (Spec	nome, farm, street, factority)			treet and Number or F n, State)	lural Route Number,
Division of To the Hospital or Attending P within 24 hours alter death. To the Funeral Director, Alfar completely filled in by the funeral Medical Certification:	29a. Certifier 1. ☐ Certifying Phy (Check only 2 ☐ Medical Exam)	sician: To the best of my kn	owledge. 332th uccum:	d at the time, date and	plane and due to the o	auso(s) and manner a	s stated
the H hin 24 the Fi	one) 20h Signatura and title of confider	ner: On the basis of examin and manner stated.		on, in my opinion, deatr		late and place, and du	
To Cor	29b. Signature and title of certifier	44.0					
1	30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, Print)			HALLARY D	26
('	BRIAN GARIBALDI	600	N. WOIFE	Street	Baltimore,	May And	2687
State Registrar		32. Registrar's Sign	done!			(-	

			For State Ragistrar	State of Maryland	-			lealth a D <i>eath</i>	nd M		giene Reg. No. 2	006	00014
			1. Decedent's Name (First, Middle, Last)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Carrie Le	ona]	Boyer	:			Januar			4:45P M
)	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. Cîty	, Town, or	Location of	Death		4c. Co	unty of Death	1
			Crofton Convales				ofton		14 1 1 an		_	e Arur	
	Funeral		5. Social Security Number 6. Sex	7. Age (<i>In yrs. la</i> IM 21X) F 97		Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	y, Year)	Cou	place (State or Foreign untry)
	Director		213-64-2216 Usual Residence of Decedent			L		li	l	Apr 1,	1908	<u>N</u>	ID
	yland 10W		10a. State 10b. County	10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mar.	ţo	MD Anne Aru	ndel Gle	n Bur	nie							1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Z	p Code				10g. Citizer	of What Cou	intry?
	23a		7811 Eleanor Drive				1061				U.Ş.A		
	teme teme	nue	TT, Marital States	12. Was Decedent Ever in U.S Amed Forces?	3.	Was Dece If Yes, sp	edent of Hi ecify Cuba	ispanic Orig in, Mexican,	jin? (Spe , Puerto l	cify Yes or No Rican, etc.)		Race - Amer Black, White	
36	within 72 hours after death with the Maryland ene. then "netural", or tieme 23a or 28a-f ehow ha Medical Examiner must be motified at	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 MNo If Yes, Give Year or Dates:		1 🗆 Yes	2₹ No	Specify:			Sp	ecify: Wh	ite
21215-0036	tura tura		15. Decedent's Edu		16a. Dece	dent's Us	ual Occupa	ation			16b. Kind	of Business/I	ndustry
15	n n	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of w DO NOT	ork done d use retired	during most ()	of workii	ng			,
212	d with	E	7	College (1-401 54)	Home	emake	r				Ow	n Home	
9	al Hy oth	Вес	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle,	Maiden Su	mame)	
<u>la</u>	Menti Menti arked	2	Edward Tayman					Emma	Sch	line			
Maryland	and and ls mu		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Addres	ss (Street a	and Number	r or Rura	l Route Numb	er, City or To	own, State, Z	ip Code)
≥,	and leelth m 27		Emma Richards Day		650 A	-	-	oad Se		na Park			C
0	f of F if of F if ite		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ R	ca	metery, crei	matory or	other plac	e) Ja	anua	_	20c. Locat	ion - City or 1	own, State
Baltimore,	t. Pa rtmen rtent:		4 Donation 5 Other (Specify)		ar Hi			ry	200	5			rk, MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Importent: if item 27 is marked other then "netural; or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinat man be notified at ance.		21. Signature of Funeral Service License					ss of Facility	OT.	ngleton Glen Bu	Fune	ral Ho	me P.A.
			23a. Part1. Enter the disease, or compli									MD ZI	Approximate
	Dharisian		shock, br-heart failure. List only or Immediate Cause (Final	ne cause on each line.		1	1/-						Interval Between Onset and Death
i.	Physician /Medical		disease or condition resulting in death)	Due to/for as a consequ		12112	IVM	19	\cap				
	Examiner		and the second s	Couper	rue	H	oal	F 4	Vail	ule			
	n ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):			- (,				
10	and	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
8760,	cete be executed physicien end the burial-transit	E	resulting in death) Last	Due to (or as a consequ	ence of):								
87	physi the t	dical		1				··					
9 X	death certific e ettending p od for use es	Physician/Me	IF FEMALE:	3c. If yes, outcome of pregnar	ncv						234	. Date of deli	ven.
Вох	etter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		☐Ectopic	oregnancy				200	Month	Day Year
P.O.	that the de ted by the e	hysi	1 □ Yes 2.2 TNo 9 □ Unknown	9□ Unknown									
<u>ر</u> ت	requires that the veen signed by th hould be deteche	by P	Part II. Other significant conditions cor	tributing to death but not resu	Iting in the u	nderlying	cause give	en in Part I.		23e. Did t	obacco use	contribute to	the cause of death?
ğ	w require been sig should b	ed	failure	to Inru	2					1 🗆	Yes 2□N	lo 3⊟Pro	bably 4 Unknown
900		plet								24a. Was		4b. Were aut	topsy findings available ompletion of cause of
Œ.	The ete h page	Completed								perfo	2 No	death? 1 ☐ Yes	
ita	ician: Th certificete rector, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death	(Check only o	one)		
× ×	Physician: this certific ral director,	၉	1 □ Yes 2 □ No		ER/Outpatie			4 Divui		ne 5 🗆 Resi			ify)
n c	ing P	ü	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injun Worl			28d. Describe	how injury o	ccurred	
Sic	Attending r death.	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	mo form at	M		Yes 2□N		ORf Location /	Stroot and A	lumbor or Pu	ral Route Number,
Division of Vital Records,	after death after death Director: A	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	reet, racto	ry, onice		1	City or To	wn, State)	amber or ria	al House Walliber,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funerei Director: After this certific completely filled in by the funeral director.		218. Centilet No Centifying Phys	sician: To the best of my know	wladya, dest	h uccurre	diat the thi	ne, date and	i plana, i	wid due to the	cause(s) an	d magner as	stated.
	1 24 P	edicai	(Check only Medical Exami	ner: On the basis of examinat and manner stated.	ion and/or in	vestigatio	n, in my o	pinion, deat	th occurr	ed at the time,	date and pla	ace, and due	to the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certifier			2	9c. Licens	e number			29d. Date s	igned (Month	, Day, Year)
	/						D	570	29	5	\ .	4-0	6
	h		30. Name and oldress of person who co	empleted cause of death (Item	23a) (Type,	Print)				tto-	^		
			Houtya Chop	ram.D.	000	Rec	ICK	MA	we	, 1251	Hnr	apdi	is, mD.Z140
	Sta Regista		31. Date filed (Month, Day, Year)	32. Registrar's Signat	basel	,)	7					

ORIGINAL

		1	For State Registrar	State of M		partment of He ertificate of D		lental Hygie	4000	00015
			1. Decedent's Name (First, Middle, I	.ast)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Alva N.	Branch				January		5.4
	Examin		4a. Facility Name (If not institution, g	ive street and number	7)	4b. City, Town, or t			4c. County of De	ath
			1630 N. Broadw			Baltim		- D / D:	N/A	
	Funeral		,	.Sex 7.A 1 □ M 2 □ TF	ge (In yrs. last birthd Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) (irthplace (State or Foreign Country)
Ц.	Director	-	214-36-0093 Usual Residence of Decedent		92 "			Aug.3,	1913 Ma	ryland
4	iow at		10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
2	a-f sh	to	MD. N/A		BAL	TIMORE				1 ☐ Yes 2 ☐ No X
1	or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What (Country?
4	23a	ai	1630 N. BROA			2121	.3		USA	
7	tams MEM	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp., Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
ဗ္ဗ	or I	by F	t ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2☐ If Yes, Give Year or Dates	X°	1 ☐ Yes 2 ☐ No	Specify:		Specify: BI	ACK
1215-0036	illed within 7.2 flouts after bean with the manyanise Hyglene. Hyglene, then "naturel", or Items 23e or 28e-f show after the Medical Examinar intest be invited at any line Medical Examinar intest be invited at	edt	15. Decedent's	Education	16a. De	cedent's Usual Occupat	tion	16	b. Kind of Busines	
212	a di	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4o	- lii	ive kind of work done du e. DO NOT use retired)	ring most of work	ing		
212	Hyglene. Hyglene. other thar ent, the M	mo:	11TH			HOUSEWIFE			HOME	
9	ntal Hy od othe event,	Be	17. Father's Name (First, Middle, La					e (First, Middle, Ma		
<u> </u>	should be lifed within 7.2 froms after beath with the wealyst and Mentale Hytlene. In arked other than "natural", or liams 23a or 28a-f show umatic event, the Medical Exant incriticat be collified at	To	WILLIAM MII	ıLARD			RC	SETTA B	ONDS	
Maryland 21	a la la la la la la la la la la la la la		19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Address (Street ar	nd Number or Run	al Route Number, C	ity or Town, State	Zip Code)
	and lealth m 27 har tr		GRAFTON BRANC	CH / SON		20 LLEWLY				
Baltimore,	0 0 1-		20a. Method of Disposition y□ Burial 2 □ Cremation 3	☐Removal from Stat	e cemetery,	sposition (Name of crematory or other place) '	20	c. Location - City of	or Town, State
֟֞֟֓֓֟֓֓֟֓֓֓֟֓֓֓֟֓֓֟֓֓֟֟֓֓֟֟֓֓֓֟֓֓֟֟֓֓֟	permit. Page Department Important: If any injury or once.		`4 □ Ponation 5 □ Other (Spe	cify)	KING M	EMORIAL P	ARK jan	.07,200	6 BALTO	,MD.
Ba	Depar Impo		21. Seture of Funeral Service Lie	2 / ATA		BALTIMORE	, MD.CA	LVIN B.	SCRUGG	S FUNERAL
			23a. Part1. Enter the disease, or or	omplications that caus		HOME 2 enter the mode of dving	1213/14	12 E PR	ESTON S	Approximate
	en anna		shock, or heart failure. List or Immediate Cause (Final	nly one cause on each	line.			. ,		Interval Between Onset and Death
	'h ysicia n /Medical		disease or condition resulting in death)	aCq	rdiamy of	Luled				2 years
E	Examiner		1	the second of						Unknown
	4.7	er	Sequentially list conditions, if any, leading to immediate	b. Due to (s a consequence of):	6,2		_!!=		
V	ansit	Examiner	Cause, Enter Universitying Cause (Disease or injury that initiated events	G						
o	an ar riai-ti	EX	resulting in death) Last	Due to (or a	is a consequence of):					
8760,	cate be executed physician and the burial-transit	dicai		d						
	Jeath certifica attending plant for use as t	Mec	IF FEMALE:	00 1			0.57	V	2122	
Box	The faw requires that the death certific tie has been signed by the attending p cage 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnancy			23d. Date of d Month	elivery Day Year
o i	the a	ysic	1 ☐ Yes 2 ☎ No 9 ☐ Unknown	9□ Unknown	at time of death	5 Other (specify)				
۵.	that the by detach	h h	Part II. Other significant condition	s contributing to death	but not resulting in th	e underlying cause giver	n in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ds,	ures signe ld be							1 ☐ Yes	2 ⊠ No 3 🗆 I	Probably 4 Unknown
Ö	w requir been si should	Completed						24a. Was an	24b. Were	autopsy findings available
Re	ne tav e has age 2	mc						autopsy performe 1□ Yes 🏖	d? death?	
		0	25. Was case referred to medical				26. Place of Deat	h (Check only one)	100	35 2 <u>35</u> NO
	Physician: this certificatal director,	To B	examiner? 1 ☐ Yes 2, ☑ No	Hospital:	itient 2 ER/Outpa	tient 3 DOA Other	r. 4 ☐ Nursing Ho	me 5 Residenc	e 6 Other (Sp	ecify)
0	ng Ph ter th neral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Ir (Month, I	njury 28b. Tim Day Year) Inju		at ?	28d. Describe how	injury occurred	
<u></u>	death. ctor: Af the fu	atic	2 Accident investiga				es 2 □No			
Division of	or Attend after death Director: / J in by the f	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	A Zee. Place of I	njury - At home, farm etc. <i>(Specify)</i>	, street, factory, office		28f. Location (Stree City or Town,	et and Number or I State)	Rural Route Number,
	To the Hospital or Attending Phi within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral					<u> </u>	- stopp vande		1 1933	
	Hospital 24 hours a Funaral I	edical		caminer: On the basis	st of my knowledge, of of examination and/o	eath occurred at the time or investigation, in my opi	e, date and place, inion, death occur	and due to the caused at the time, date	se(s) and manner a a and place, and di	as stated. ue to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	O and marrier	stateu.	29c. License	number	290	. Date signed (Moi	nth, Day, Year)
•	- ≱ = 8		· Phand	Sto	MD	RES	5-000	Ton	very 4	2006
	\wedge		30. Name and address of person	no completed cause of	f death (Item 23a) (To	pe. Print)		047)	8 /	2000
	4		Bridy Stein	601 N.	oth Caroline	Street Bal	hmore M	ryland	21287	1
	Sta	ate	31. Date filed (Month, Day, Year)	32. F	strar's Signature	29c. License Pe, Print) Street Ba/		1		
	Regist	rar	JAN 0 5	2006	en At	Agran				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. t's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2*00X* 2006 anuary /Medical 4b. City Town, or Location of Death 4c. County of Death Examiner altimore Memoria If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Security Number 6. Sex If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 7-12-336 2 🗆 F Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-4 show other treumstic event, the Madical Executors Fourt be notified at 1 Ses 2 □ No Funeral Director HIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21 death v 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Forces' filed within 72 hours after 1 Never Married 2 Married Yes 2 □ No Baltimore, Maryland 21215-0036 Yes, Give rear or Dates 1 Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. gndary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is merked other eny injury or other treumatic event. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition

Burial 2 Cremation 20b. Place of Disposition (Name of 10 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Name and Addre res 23a. Part: Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 H R Immediate Cause (Final disease or condition resulting in death) CARDIOVASCULAR COLLAPSE Physician /Medical Due to (or as a consequence of): Examiner 20 YRS COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospitel or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of) attending physicien Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death P.O. ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No 20 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) Time of 28d. Describe how injury occurred Injury at Work? After Injury s after decrei Alterior in the firm 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel L 1 Cartifying Physician: To the best of my knowledge death occurred at the line date and clans and due to the nause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JAN 3, 2006. D 0058860 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO, MD CALVERT ST. SUITE SSS MO 3333 N. 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIĞINAL

		-	For State Registrar	State o	f Maryland		artment of H		d Mental Hy	-61	06	00017
			Hegistrar Decedent's Name (First, Middle	o, Last)					2. Date of De	Reg. No.		3. Time of Death
	Physicia		Sophie		J.		Borkows	ki	Month Januar	Day	2006	5:05 P M
	/Medic		4a. Facility Name (If not institution				4b. City, Town, or				ounty of Death	
	Examin	er	Continnum Care	-			Sykes		,0411		Carroll	
			5. Social Security Number	6 Sav	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	th	O Rieth	place /Ctate or Foreign
	Funeral Director		216-12-6143	1 M 2 DF)2 Yrs.	Months Days	Hours I	Min. (Month, Da May 18	iy, _{Year)} 3 1913	Mar	yland
		1	Usual Residence of Decedent	22					1147 1)
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mar	ţo	Maryland Carrol	L1	Skys	ville						1 Yes 2 No
	r 28e	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Cou	ntry?
	3a o	0	2810 Kaywood I	Place			21784		1	U.	S.A.	
	ms 2	Jere	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U.S	3. 13.	Was Decedent of Hi	spanic Origin	? (Specify Yes or No Puerto Rican, etc.))- 14.	Race - Ameri	
9	after or ite	F	1 Never Married 2 Marr		2 XNo		ires, specily cubal 1 □ Yes 2 □ No		dello nican, etc.)	- 1	Black, White,	
5-0036	filed within 72 hours after death with the Maryland Hygiene. wher then "naturei", or Items 23a or 28e-f show ant, the Medical Examinat must be notified at	d by	3 XWidowed 4 ☐ Divorced	Year or D	ates:		1 163 2 DA 110	эрвспу.		3,	ресіfy: Wh	ite
5-0	natu dical	Completed	15. Decedent (Specify only highes	t's Education at grade completed)		(Give	dent's Usual Occupa kind of work done of	lurina most of	f working	16b. Kind	of Business/In	ndustry
2	ithin Ne.	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)				
7	filed with Hygiene. other than	S	6	NA NA	-	S	eamstress	40 14-15-15			ng Fac	tory
ğ	m - 0 2	Be	17. Father's Name (First, Middle,	Last)					Name (First, Middle	, Maiden Su		
<u>X</u>	should be and Mentel a marked o	၉	Constantine		Krop	kowsk:			erine		Celm	
Maryland 2121	2 sh and is m		19a. Informant's Name/Relations				_		or Rural Route Numb			
d)	1 and Heelth em 27 ther ti		Milton Borkows	ski (Son		the same of the sa	21 Springs sition (Name of	wood Co	Ourt Ellic			
altimore,	Pages 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from	Ct C6	metery, crei	matory or other place	^{θ)} ¦Ja			tion - City or T	
E	tmen tent: jury		* 4 □ Donation 5 □ Other (S		State St'		islaus		nuary 5,	baltim	nore, M	aryland
Bai	permit. Pages 1 and 2 should be Department of Heelth and Mente importent: if tiem 27 is marked any injury or other treumatic ex once.		21. Signature of Funeral Service	Licenses	2	1 2	W. Dahros		hojnacki 1	Tunera	1 Home	s P.A.
-	00 F 4 0		1/ask(In She	med	e-	1005 Dun	dalk Ar	WA Ralto	Md		
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	dused the death ach line.	. Do not en	er the mode of dying	g, such as car	rdiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Paysician		Immediate Cause (Final disease or condition	_a/	Der	nen	19				1	Oriset and Death
В	/Medical Examiner		resulting in death)	Due to	(onas a consequ	ence of):	10.					
В	LAditille		Sequentially list conditions, if any, leading to immediate	b	DEDY	1516	4					
7	sit sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consequ	ence of):						
V	and -tran	Examine	that initiated events resulting in death) Last	c. Due to	(or as consigu	ance of	9				-	
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	physics the	dicai		d							1	
ox 6	ding se as	/Me	IF FEMALE:	23c If yes ou	tcome of pregnar	ncv.				20.	4 D-1- +6 d-15-	
Bo	The law requires that the deeth certific ate has been signed by the attending p bage 2 should be detached for use as:	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	oirth 2 ☐ Fetal nant at time of de	death 3	Ectopic pregnancy Other (specify)			230	 Date of deliv Month 	Day Year
o.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkr		aui st						
۵.	that the de ed by the detached		Part II. Other significant condition	ons contributing to d	eath but not resu	Iting in the u	nderiving cause give	en in Part I.	23e. Did 1	obacco use	contribute to t	the cause of death?
ģ	uires tha slgned I d be det	l by							1 🗆	Yes 2⊠i	No 3□Prol	bably 4 Unknown
Ö	w requir been sl should	etec									245 244	Cadiaca available
š	e law has l	Completed							24a. Was		prior to co death?	opsy findings available ompletion of cause of
2	r: Th								1 ☐ Yes	2 No	1 🗆 Yes	2 □ No
	iciar certif ectol	Be	25. Was case referred to medical examiner?	Hospital:			othe Othe	20	Death (Check only			
ot	Phys this aldir	2	1 Yes 2 No	28a. Date	Inpatient 2 E	R/Outpatier 28b. Time o	IL 3 DOA	22 INUISI	ng Home 5 Resi 28d. Describe			fy)
L C	Attsnding Physician: Ir death. sctor: After this certifica	io.	1 ☑Natural 5 ☐ Pendin	g (Mor	th, Day Year)	Injury	Work			now injury c	occurred.	
Sic	ttsnd death tor: /	icat	2 Accident investig	not be	of Injury . At ho	ma farm at	reet, factory, office	193 2 110	_	Stroot and A	Vumber or Pur	al Route Number,
Division of Vital Records,	To the Hospitei or Attending Physician: The within 24 hours eiter death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification;	4 Homicide determine	ined build	ing, etc. (Specify)	eet, factory, office		City or To		10 171007 07 1107	ar riobto rambor,
_	To the Hospitel or within 24 hours efter To the Funerel Dirt completely filled in the formal of the formal of the formal of the filled in the formal of the filled in the formal of the filled in the	Ö	29a. Certifier 1√ Certifyin	o Physician: To th	a hast of my know	vladna daat	h accurred at the tim	o date and n	place, and due to the	cauca/c) an	nd mannat as s	stated
	Hos 24 hc Fun etely	edicai		Examiner: On the b					occurred at the time,			
	To the within 2 To the complet	Me	29b. Signature and title of pertifie				29c. License	number		29d. Date s	signed (Month,	Day, Year)
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	^		30 Name and address of a	who consisted saw	no of don't flor	230) /Tuna	Print) 4	0 0 1	, ,	- 4		6 V 21159
	1		30. Name and address of person	wito completed cau	n eu	344	malea	ind	whe, We	nm	inster !	1) 2115m
	1											
		10	31. Date filed (Month. Dav. Year)	32 1	gistrar's Signat	ure						
	Sta Registr		31. Date filed (Month, Day, Year)		gistrar's Signat	ure	do de					

	1 - For State Registrar	_	Department of Health and Certificate of Death	Mental Hygien	2006 00018
Physician /Medical Examiner	1. Decedent's Name (First, Middle LULA M	BURKINDINE give street and number)	4b. City, Town, or Location of Deat	2. Date of Death Month D ANUADY	year Year 3. Time of Death A 2006 8:58 M
Funeral Director	RALTIMORE WASH 5. Social Security Number 216–20–4922 Usual Residence of Decedent	1.NGTON DEDICAL CENT 6. Sex 7. Age (In yrs. last birt 79	red OLEN BURNI hday) If Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min.	8. Date of Birth	P. Birthplace (State or Foreign Country) MD
death with the Maryland ms 23e or 28e-f show rmust be notified at meral Director	10a. State 10b. County MD Anne A	Arundel GI	or Location Len Burnie	10g. C	10d. Inside City Limits 1 ☐ Yes 2 No Citizen of What Country?
<u>ĕ</u> ≝ ≝ .5	410 Irene Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2₹□ SNo If Yes, Give	21061 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 X No Specify:		U.S.A. 14. Race - American Indian, Black, White, etc. Specify: white
Baltimore, Maryland 21215-0036 Deartin Pages 1 and 2 should be filed within 72 hours after Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Department of the page 1 marked other than "natural, or lie many injury or other traumatic event, the Medical Examination. To Be Completed by Further	15. Decedent (Specify only highes Elementary/Secondary (0-12)	Year or Dates: s Education t grade completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) Sales	rking 16b.	Kind of Business/Industry Retail
ODIDE LULLOSSE Maryland 212. Set and 2 should be filed within of Heelth and Mental Hygiene. Item 27 is marked other than a rother traumatic evant, the Maryland Comp.	Albert Alfonso	Leggett	18. Mother's Na.	me (First, Middle, Maide	en Sumame)
Baltimore, Malpernit. Pages 1 and 2 st Department of Heelth and more discounted in the 27 fs rank in the 27 fs rank injury or other treaugues.	19a. Informant's Name/Relationsl Mr. George W. I 20a. Method of Disposition 1 € Burial 2 □ Commation	Burkindine/husband	Mailing Address (Street and Number or Red 410 Irene Drive; G1 Disposition (Name of y, crematory or other place)	en Burnie,	
Baltimore, Baltimore, permit. Pages 1 an Department of Heal Important: If tiem 2 any injury or other once	4 □ Donation S □ Other (S) 21. Signature of Further I Service	1	Nen Memorial Pk 1- 22. Name and Address of Facility S 1 Second Ave SW;	ingleton Fu	
Pnysician //Medical	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that caused the death. Do nonly one cause on each line. a	onitis	c or respiratory arrest,	Approximate Interval Between Onset and Death
3760, < attended the be executed the burial-transit and the burial-transit the burial Examiner at the standard transit the standard transit the standard transit the standard transit the standard transit the standard transit transi		b. Due to for as a consequence of the consequence o	ted Hictor h	ernia	1000
P.O. Box 68 nat the death certificate by the attending pt letached for use as a physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
cords, P wrequires that been signed b should be deta letted by PP	Part II. Other significant condition	ons contributing to death but not resulting in	the underlying cause given in Part I.	1 □ Yes	o use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Vital Record slcien: The law requir certificate has been s rector, page 2 should	25. Was case referred to medical		26. Place of De	24a. Was an autopsy performed? 1 Yes 2 Tath (Check only one)	
on of ding Phys	1 ☐ Yes 2 ☐ 1/0	g (Month, Day Year) In	Time of plury at Work? M 1 Yes 2 No	dome 5 Residence 28d. Describe how inj 28f. Location (Street and City or Town, Sta	jury occurred and Number or Rural Route Number,
Divisi To the Hospital or Attentition 24 hours after deal To the Funeral Director: completely filled in by the	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physicien: To the best of my knowledge Examiner: On the basis of examination an and manner stated.	e, death occurred at the time, date and place d/or investigation, in my opinion, death occu	e, and due to the cause urred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
To th within To th comp	29b. Signature and title of certifie	who completed cause of death (Item 23a)	29c. License number D J 4 J 8 (Type, Print) Charles	29d. C	ANULTY 1 2006
State	U/111 12 22 / 121	Ucishing for Med 32. Registraria Signature	icul Center 3011	Hospital D	rive Glen Bornie MI

			For State Registrar	State of M	aryland / De <i>C</i>	partment o e <i>rtificate</i>			ntal Hygie Reg.	ZUUE	00019
	Physici	an	1. Decedent's Name (First, Middle, Last) Milton Frede	rick	Cox				Date of Death Month Nuary	03 200°	3. Time of Death 5:00 AM
	/Medic Examin	2.0	4a. Facility Name (If not institution, give s	treet and number)			wn, or Location	of Death	iidai y	4c. County of D	Peath
		2	Anne Arundel Medic 5. Social Security Number 6. Sex		r ge (In yrs. last birthda		nnapol (r 24 Hrs. R	Date of Birth	9	Arundel
	Funeral Director		214-12-8974 ^{1X}	M 2□F	83 Yrs.	Months D	ays Hours		(Month, Day, Ye	1922	Birthplace (State or Foreign Country) MD
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
	Ba-1 eh	Director	Maryland Queen Ar	ine		S	tevens	ville			1 ☐ Yes 2 🔀 No
	with th		316 Cecil Road			10f. Zip Co	ode 216	566	10g.	. Citizen of What	•
	eme 2:	Funeral		2. Was Decedent Armed Forces		3. Was Deceden	t of Hispanic O		Yes or No-	14. Race - A	American Indian, Vhite, etc.
39	J within 72 hours after death with the Maryland jiene. r than "natural", or Iteme 23a or 28a-1 ehow the Madical Examinar must be notified at	۵	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ Il Yes, Give Year or Dates:	No	1 ☐ Yes 2 🔀			,	Specify:	White
2-0	72 hou	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. De	cedent's Usual C ive kind of work on b. DO NOT use r	Occupation done during mo	st of working	168	b. Kind of Busine	ess/Industry
2121		Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	n. <i>DO NOT</i> use <i>i</i> Mecha				Fork	Trucks
Baltimore, Maryland 21215-0036	2 should be filed and Mental Hygi Is marked other sumatic event, II	Be	17. Father's Name (First, Middle, Last)	Cov					irst, Middle, Mai		
ıryla	ges 1 and 2 should be filed tof Health and Mental Hyg If Itam 27 is marked othe or other traumatic event,	2	Milton W. 19a. Informant's Name/Relationship (Ty)	COX	19b. Ma	ailing Address (S		Bertha Ber or Bural Bo	Lii		te. Zip Code)
, Ma	alth 27		Linda L. Hixon	(daughte	r) P.(). Box 2	44, Ree				
Jore	ages 1 nt of He : ff itan		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ R	emoval from State		rematory or other Ven Ceme	r place)		07	c. Location - City	or Town, State ie, Maryland
altin	permit. Pages 1 a Depertment of He Important: if Itam any injury or othe		4 □ Donation 5 □ Other (Specify) 21. Signature of Feneral Service 1 c. Asset	ne /	dien na	22. Name and A	1	2006 Ility Sta			Home, P.A.
ä	P P E E) Sund. 34	1.				in Road	, Pasad	ena, MD	
ı			23a. Part1. Enter the disease, or consistency or heart failure. List or ly on Immediate Cause (Final	cations that cause e cause on each I	d the death. Do not ine.	enter the mode o	l dying, such a	is cardiac or re	spiratory arrest		Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)		a consequence of):	C			10		-
8.5	Examiner	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	. — Due to (or as	a consequence of):						
V	acuted nd transit	Examin	that initiated events								
8760,	sate be executed obysicien and the burial-transit		resulting in death) Last	Due to (or as	a consequence of):						
9	rtificate ng phy:	Aedical	IF FEMALE.	•							
Вох	death certificate be executed e ettending physicien and nd for use es the burral-transit	Physician/Me	in the past 12 months?	3c. If yes, outcome 1□Live birth 4□Pregnant a	2 Fetal death	3 □Ectopic pregr 5 □ Other (speci				23d. Date of Month	delivery Day Year
P.O.	the che	hysi	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown	i iiiio oi dodiii	outor (apoci.					
Ś	requires that een signed by hould be deta	þ	Part II. Other significant conditions con	tributing to death t	out not resulting in the	underlying caus	se given in Part	H	23e. Did tobac		e to the cause of death? Probably 4 Unknown
Vital Record	S S S	ompleted							24a. Was an autopsy	24b. Were	autopsy lindings available to completion of cause of
a B	The ete h page	O							performed	No 1 🗆	h?
Vit	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?	ospital:	ent 2 🗆 ER/Outpa	tient 3 DOA	Other	ce of Death (Constitution)		e 6 ⊡Other (3	Specify)
n of			27. Manner ol Death	28a. Date of Inju (Month, Da		e of 28c.	Injury at Work?	28d.	Describe how		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division	en or:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm,	M street, factory, or	1 ☐ Yes 2 ☐		Location (Stree	et and Number o	r Rural Route Number,
ā	0 = = <	Cert	4 Homicide		tc. (Specify)				City or Town, S		
	To the Hospital of within 24 hours a To the Funeral Completely filled in	edica	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best ner: On the basis of and manner si	of my knowledge, de ol examination and/o tated.	eath occurred at to r investigation, in	the time, date a my opinion, de	and place, and eath occurred a	due to the caus it the time, date	e(s) and manne and place, and	r as stated. due to the cause(s)
	To the Within 2.	M	29b. Signature and title of certifier	1		29c. L	icense number	107	29d.	Date signed (M	lonth, Day, Year)
	Λ		30. Name and address of person who co	mpleted cause of	death (Item 23a) (Typ	pe, Print) N	177	A .	/ ()	113	106
	1		Amos Yu			A.	ne	Avva	120	Media	a (enter
	Sta Registi		31. Date liled (Month, Day, Year) JAN 0 6 2008	160	rar's Signature	ENE !					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar		Certifica	te of Death	Reg.	2006	00020
	Physicia		1. Decedent's Name (First, Middle, Last) Z A NE S	EARL C	VPRF	55 SR.	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	1	, Town, or Location of Deat		4c. County of Deatl	
1,000			5+. Hgnes Healt 5. Social Security Number 6. Sex	heare 7. Age (In yrs. Ia		altimore or 1 Year If Under 24 Hrs	8. Date of Birth	A. Bird	Place (State or Foreign
	Funeral Director			M 2 F 7. Age (III y/s. la	9 Yrs. Months			ar) 1926 V	IRGINIA
	how thow		10a. State 10b. County	10c. City,	Town or Location		1	,	10d. Inside City Limits
	he Ma	Director	MARYLAND NI	A		ALTIHO,		1/	1 ⊠Yes 2 □ No
	hours after death with the Maryland turel', or Itema 23e or 28e-f show at Exercinal must be notified at			SUTH STR	EET	p Code 2/22	9	Citizen of What Co	7
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	 Was Decedent Ever in U.S Amed Forces? 1 XYes 2 □ No 	i. 13. Was Deci	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
5-0036	rel', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	2 No Specify:		Specify: BL	ACK
15-0	n 72	Completed	15. Decedent's Educ (Specify only highest grade		16a Decedent's Us (Give kind of w life, DO NOT	ork done during most of wo	rking 16b	. Kind of Business/	industry
2121	filed within Hygiene.	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	~	ERK	F	EDERAL	GOVERNMENT
-	be filed tal Hygid d other	Bec	17. Father's Name (First, Middle, Last)	- 0		18. Mother's Na	me (First, Middle, Maid	den Surname)	,
Maryland		P	LANES	5 CYA	PRESS	LAUL	2A 0		ERRY
Ma	a a a		19a. Informant's Name/Relationship (Ty)	PRESS (WIFE)		s (Street and Number or R			
ore,	of Health of Health if Item 27 or other tr		20a. Method of Disposition 1 Ø8urial 2 □ Cremation 3 □ R	20b. Pla	ace of Disposition (Nametery, crematory or	SSUTH 57 ume of other place)	Pate 20c	. Location - City or	Town, State
Baltimor	Page 11 7		4 ☐ Donation 5 ☐ Other (Specify)	, DR	UID RIDE	ECEME 01-	17-06 P	IKESVILL	E, MD.
Bai	pernit. Pag Department Important: any njury once.		21. Signature of Funeral Service License	1. Willian	22. Name a	and Address of Facility B	ROWN JR.	FUNERA BALTO, M	16.21217
* .5			23a. Part1. Enter the disease, or compliant shock, or heart failure. List only on	cations that caused the death. e cause on each line.					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequent	Inter	elu			16.00
4.	Examiner		Committee of the commit	1	•	voyell d	iscule.		5000
	pe sit	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque					
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):				
68760,	ysicia ysicia of buri								
-	entifica ding ph	Medical	IF FEMALE:				===		
O. Bo)	ath c	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal 9 ☐ Unknown	death 3 Ectopic			23d. Date of deli Month	very Day Year
σ.	that the de led by the a detached t		Part II. Other significant conditions con	tributing to death but not resul	Iting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Records,	quires en sign	ed by	cardonyopany	, rend In	g- Horney		1 ☐ Yes	2 ☐ No 3 ☐ Pro	obably 4 Sonknown
eco	e law requ has been je 2 should	Completed	•		•		24a. Was an autopsy	prior to d	topsy findings available completion of cause of
al R					13.73/201		performed 1 ☐ Yes 2 ☐	? _ death?	2 🗆 No
Vital	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatient 3 ☐ E	1 04	ath Check only one	2 701(2	
J of	ding Physin. After this funeral di	n; To	27. Manner of Death		28b. Time of Injury	28c. Injury at Work?	dome 5 Residence		erfy)
sior	eath. or: Af the fur	catio	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		М	1 Yes 2 No			
Division	tel or Att rs after d al Direct ed in by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, facto)	ry, office	28f. Location (Street City or Town, St	t and Number or Ru tate)	ral Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the funer	Medical	29a Cartifier 1 The Billying Physical (Check only one) 2 Medical Examination	ician: To the best of my knowner: On the basis of examinati and manner stated.	viadga daalih ommur a ion and/or investigatio	d at the thre, date and claon, in my opinion, death occ	e, and due to the cause urred at the time, date	and place, and due	ctated. to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	_	2	ec. License number	29d.	Date signed (Monti	
•	100		100)-	M	1	36-5848998	Ja	meny 63,	2006
10	1-1		30. Name and address of person who con Robert Greento H. 31. Date filed (Month, Day, Year)	mpleted cause of death (Item	23a) (Type, Print)	The Agree of	rept 1	71736	
	- Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure	2		0.009	

Cypless Zanes

	•	For State Registrar	Sta	ate of M	laryland		rtment of H tificate of L		-	giene Reg. No.	006	00021
Physicia	in.	1. Decedent's Name (First, Middle	e, Last)				_		2. Date of Dea	Day	Year	3. Time of Death
/Medic		Martin			rome		Conne		January		2006	12:01 AM
Examin	er	4a. Facility Name (If not institution Johns Hopkins I	-			enter	4b. City, Town, or Baltin		n	4c. C	ounty of Death INA	1
Funeral		5. Social Security Number	6. Sex	7. A	ge (In yrs. la		If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h ,	9. Birth	nplace (State or Foreign
Director		216-48-0896	1 ₹ M 2	2 F	5	6 Yrs.	Months Days	Hours Min.	(Month, Da)	25 19	49 Ma	ryland
pug 3		Usual Residence of Decedent 10a. State 10b. County			10c. City	. Town or Lo	ation					10d. Inside City Limits
Maryle f •ho	٥		. T A									1₽Yes 2□No
28a-	Director	Maryland 1 10e. Street and Number	NA		ва	<u>ltimor</u>	e 10f. Zip Code			10g. Citize	n of What Co	untry?
h with		22 North Kres	sson S	treet			21224	I			U.S.	Α.
ours after death with the Marylen ai', or itams 23s or 28s-1 show Exercities mast be ricitified at	Funerai	11. Marital Status	A	as Decedent	? 107	S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-	. 14	. Race - Amer Black, White	
or it	by Fu	1 Never Married 2 Marr	ned 1.	Yes 2 Tes, Give	No 197	2	☐ Yes 2☐ No	Specify:	, ,		pecify:	
		3 Widowed 4 Divorced		ear or Dates:	-	16a Deced	ent's Usual Occupa	ition	1	16h Kinc	Wh of Business/I	ite
n na n na	Completed	(Specify only highe: Elementary/Secondary (0-12)	st grade com		5.1	(Give	kind of work done of OO NOT use retired	uring most of wor	rking	700. (1110	01 54511000	Company
d with	mo:	12		NA	3+)	Elect	rician			Ente	rprise	Electric
be filed within 72 ho ital Hygiene. Id other then "natu	Be (17. Father's Name (First, Middle,	Last)					18. Mother's Nar	ne (First, Middle,	Maiden S	umame)	
12 should be filed within h and Mental Hygiene. Fie marked other than "reumatic event, the Market	10	Martin		seph		Conn		Delor			Faulk	
to, man yield yield yield the stand and Mer the stand Mer traumatic		19a. Informant's Name/Relations			- \		g Address (Street a			-		
Heal Heal tem 2		Delores Conner 20a. Method of Disposition		Mother	20b. Pf	ace of Dispo	sition (Name of		Date Dail		tion - City or	Tand 21224 Town, State
Pages ent of nt: if i		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		al from State	•	-	natory or other place	Janu	ary 9,	Oraino	c Mill	s, Maryland
permit. Pages 1 and 2 Department of Health s Important: if item 27 is eny injury or other tra		21. Signature of Fyheraf Service			barr	/) 22	orest Vet Name and Addres W. Dabro	s of Facility Ch	oinacki			
Depermi Impo Impo ony ii		1/ Jark	1	Logs	und	ri						and 21224
		23a. Part1. Enter the disease, or shock, or heart failure. List	complication only one cal	ns that cause use on each	line.		0		or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	a	N	1 you	ardia	. Inta	viction				Onset and Death
/Medical Examiner		resulting in death)		Due to (or a	s a consequ	ience of):	.l Infa	Cecco				2002
	er	Sequentially list conditions, if any, leading to immediate	b. —	Due to (or a			urtery c	uscase				2002
ate be executed hysicien end the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S .									
be executed icien end burial-transit		resulting in death) Last	ŭ	Due to (or a	s a consequ	ence of):						
ote be cate be chysicient the buri	licai		d									
uires that the death certifications that the attending principle of the attending principle of the detached for use as the	Physician/Med	IF FEMALE:	220 16									
attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1	yes, outcom □Live birth □Pregnant a	2 Fetal	death 3	Ectopic pregnancy Other (specify)			23	d. Date of delimental delimen	very Day Year
the d	ysic	1 Yes 2 No 9 Unknown		Unknown	21 11110 01 00	30	Cirio (Specify)					
s that	by Pt	Part fl. Other significant condition	ons contribut	ting to death	but not resu	Iting in the ur	derlying cause give	en in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
w requires been sig should b	ed b	Hypertensi	on	,					101	′es 2□	No 3 ⊠ Pro	obably 4 Unknown
law re Bs be 2 sho	piet	Hyper lipid	emià						24a. Was		24b. Were aut	topsy findings available
vical necessician: The law scertificate hes t	Completed	Diabetes n	nellit	us					perfo	med?	death? 1 ☐ Yes	
ician: sartific actor,	Be	25. Was case referred to medica examiner?	-				104		ath (Check only o	пе)		
Phys this rel dir	2	1 ☐ Yes 2 🛣 No 27. Manner of Death	Hospit 28	i ∐ inpat		ER/Outpatien 28b. Time of		4 🗆 Nursing F	lome 5 Resid			cify)
ding th: After	atlon:	1 Natural 5 Pendir 2 Accident investi		a. Date of fn (Month, D	ay Year)	Infury	28c. Injury Work	:?` fes 2∐No	200. 00001100 1	iow injury	occurred.	
Atter r dea ector by the	ifica	3 Suicide 6 Could	not be	e. Place of Ir	njury - At ho	me, farm, str	eet, factory, office				Number or Ru	ral Route Number,
s effe	Certific	4 E Homiciae		bullaing, e	etc. (Specify	7			City or Tow	m, State)		
Livision of Attending Physician: The law requires that the death certificate within 24 hours eiter death. To the Funeral blactor: After this certificate has been signed by the attending physic or the Funeral blactor. After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the I	Medicai	29a. Certifier 1 X Certifyin (Check only one)	Examiner: (On the basis	of examinat	wiedge, death ion and/or inv	occurred at the timestigation, in my op	e, date and place pinion, death occu	e, and due to the corred at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
o the rithin 3 o the omple	Med	29b. Signature and title of certifie	-	and manner s			29c. License	number		29d. Date	signed (Month	, Day, Year)
► \$ ⊢ ŏ		> Sola ali	Mico				DO	035363			y 6,20	
2+1		30. Name and address of person	who comple	ted cause of	death (ftem	23a) (Type,					-	
91'		Sandra Ma	vehall.	MD	VAMH	cs 1	North North	Greene	St. Bo	Utim	ore Mi	D 21201
Sta Registr		31. Date filed (Month, Day, Year)			trar's Signat	ture					,	
negisti	a:	JAN 0 6 2	1006	E CONT	1 18.	fine						

Please Type or Print in Black Bedelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

Month

		For State Registrar	State of Maryland		tificate of l			Reg. No.)6	00022
Phys	ician	1. Decedent's Name (First, Middle, Last					2. Date of De Month	Day	Year	3. Time of Death
	dical	Catherine R. Con			4h City Town or	Location of Death	Januar	-	y of Death	0015 [™]
Exan	niner	Montgomery Genera	•			Eddarion of Badin			gome	
Funer	al .	5. Social Security Number 6. Se		ast birthday)	Olney If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da		9. Birth	place (State or Foreign
Directo		156-14- 1528	□M 20XF 82	Yrs.	Months Days	Hours Min.	Oct. 2	18, 1923	New	Jersey
р ,		Usual Residence of Decedent 10a. State 10b. County	10a Cibe	, Town or Lo					-	101 111 1
anyla shov	_				cation					10d. Inside City Limits 1 ☐ Yes 2 No
he M	ecto	Maryland Montgome	ry 01n	еу	100 7: 0 1			10 00:	1477	
with t	ă	10e. Street and Number	G		10f. Zip Code			10g. Citizen of		•
eath	era	19312 Madison Hot	12. Was Decedent Ever in U.S	13 1	20832	isnanic Origin? (Sr	activ Yes or No	United		tes ican Indian,
permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, it a Medical Evar dust inval the rottlined at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2ሺ No		Rican, etc.)	Speci	ck, White	, etc.
n 72 hou n "natura le Jical E	Completed		ucation le completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing	16b. Kind of 8		ite ndustry
withi ene. than	I E	Elementary/Secondary (0-12)	College (1-4or 5+)		nemaker	,		Own	Home	
Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	Maiden Suma	m <i>e)</i>	
lid be lental ked (To B	Eugene Rhein				Sara	Ellen Cornis	Corni	sh	
shou and M mar umal		19a. Informant's Name/Relationship (T	vpe, Print)	19b. Mailir	ng Address (Street	and Number or Rui	al Route Numb	er, City or Towr	, State, Z	p Code)
alth alth 27 is		Thomas L. Corwin	, Jr./Husband	19312	Madison	House St	reet, C	lney, M	lary1	and 20832
of He of He		20a. Method of Disposition 1 Darial 2 Cremation 3 D	20b. Pl	ace of Dispo	sition (Name of		ary 5,	20c. Location		
Page nent ant: if		4 Donation 5 Other (Specify,		tgomer matori	ium. Inc.	2006	•	Bethes	da,	Maryland
permit. Departr Imports any inju	SUCE	21. Signatul o Funeral S, rvice Lickh		803 RG	Name and Address	Inc. 300	West M	Pumphre lontgome	y Fu ery A	neral Home venue
Physicia /Medica Examine	al	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequ		al In-	farctio	η.			Interval Between Onset and Death
tificate be executed g physicien and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque c. Due to (or as a conseque							
cate be ohysicie the burn	Aedical	(d.		=					-
death cer e ettendir id for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3[Ectopic pregnancy Other (specify)				ate of delik	rery Day Year
that ed by deta	Ph/	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did 1	obacco use cor	tribute to	the cause of death?
uires sign d be	d b						1 🗆	Yes 2∭ No	3 🗌 Pro	bably 4 Unknown
The law requires that the sate has been signed by the page 2 should be detached.	Completed						24a. Was auto perfo	psy ormed?		opsy findings available ompletion of cause of
ician: Th certificate ector, pag	Be	25. Was case referred to medical				26. Place of Deal				
Physician: r this certificated director.	ုင	1 ☐ Yes 2X No	Hospital: 1 X Inpatient 2 🗆 E	ER/Outpatier	t 3 DOA Othe	er: 4 Nursing Ho	ome 5 Resi	dence 6 □Ot	her (Spec	fy)
Attending P or death. ector: After t by the funera	Certification:	27. Manner of Death 1 Katural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time o Injury	Worl	yat ⟨? Yes 2 □No	28d. Describe	how injury occu	rred	
al or Attend s after death il Director: /	Sertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho- building, etc. (Specify	me, farm, str)	eet, factory, office		28f. Location (City or To		ber or Rui	al Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsicien: To the best of my know iner: On the basis of examinate and manner stated.	ion and/or in	vestigation, in my of	oinion, death occur	red at the time,	date and place	and due	to the cause(s)
To th withir To th	M	29b. Signature and title of certifier	omplited cause of death (Item 141), M.D. 205		29c. License	number/Narg	land	29d. Date signe	ed (Month)	Day, Year)
\mathcal{F}_{0}		30. Name and address of person who of	ompleted cause of death (Item	23a) (Type,	Print) ecaMeado	ws Prkwy	, Germ	autour,	MD	20876

State Registrar 31. Date filed (Month, Day, Year) . 32. Registrar's Signal

JAN 0 6 2006

32. Registrar's Signature

				State of Maryland / Department of Health and M	•	•	00023
				1 - State Registrar Certificate of Death		g. No.	UUUZJ
		Physici	an	1. Decedent's Name (First, Middle, Last)	Date of Death Month	Day Year	3. Time of Death
		/Media	al	Bernhard M. Callender 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	01	4c. County of Dea	0 /
	-	Examir	ier	Good Samaritan Hospital Baltimore			
	-	Funeral	•	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Bi	A thplace (State or Foreign ountry)
	20	Director		307-10-6139	OCT 31,	1916	Iowa
		land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		Mary F-f sh	tor	Maryland N/A Baltimore			1 XYes 2 □ No
		ours after death with the Marylar rat', or tteme 23a or 28e-f show Examinar must be notified at	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What C	ountry?
- 2		e 23a		2727 Chesley Avenue 21234		USA	
20	40	iter de	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never M	Rican, etc.)	14. Race - Am Black, Wh	
le	5-0036	ral', or	Ď	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		Specify:	White
allende	5-0	within 72 hours after death with the Maryland sne. then "natural", or iteme 23a or 28e-f show the Medical Exami an must be rodified at	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) (If DO NOT use retired)	ang 1	6b. Kind of Business	s/Industry
C	2121	within ene. then	dmo	Elementary/Secondary (0·12) Colfege (1·4or 5+) 5+ Civil Engineer		II C Const	- C 1
1		should be filed nd Mental Hygi marked other umetic event, II	Be Co		e (First, Middle, M	U.S. Coast	Guard
8	/lar	2 should be and Menta te marked aumetic ev	To B	Charles Lee Callender Alma	a M. Jaco	bson	
ha	Maryland	S 40 2 4		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run			Zip Code)
rnha		lan leal leal		Virginia J. Callender/Wife 2727 Chesley Avenue 20a. Method of Disposition (Name of		ore, MD 21	
2	Baltimore	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery, crematory or other place)			
12	alti.	permit. Page Department of Important: If any injury or once.		fietto orematory, inc. 173		Baltimore	f MD, Inc.
	m	D C C C C C C C C C C C C C C C C C C C		Edward A. Gregorchik 299 Frederick Roa	d Balti	more. MD 1	1 MD, Inc. 21228
	72			23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	st,	Approximate interval Between
		Physician		Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Tnfa	rction	}	Onset and Death
		/Medical Examiner		Due to (or as a consequence of):			
	1		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
Ko		acuted and transii	Examiner	that initiated events C.			
	760,	te be executed ysicien and ie burial-transit	cal Ex	Due to (or as a consequence of):			
		# > @		d.			
	Вох 68	leath certificat attending phy I for use as th	M/U	IF FEMALE: 23b. Was decedent pregnant in the anst 13 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	elivery
	Э.	Physician: The law requires that the death certifica this certificate hes been signed by the attending phral director, page 2 should be detached for use as the	Physician/Med	in the past 12 months? 1		Month	Day Year
	P.O.	that the de led by the a detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did toba	acco use contribute l	o the cause of death?
	of Vital Records,	uires tha n signed	d by	Congestive Heart Failure	1 ☐ Yes	/	robably 4 Dunknown
	000	aw require s been sig 2 should t	Completed	Atoral Fibrillation	24a. Was an		utopsy findings available
	- R	The lav ate hes page 2	Com	Aortic Stenosis	autopsy perform 1 Yes 2	ed? death?	completion of cause of
	Vita	ysician: The l is certificate he director, page	Be	25. Was case referred to medical examiner?	th (Check only one		
	of	Physic rthis raldir	- To		ome 5 Resider	nce 6 Other (Spe	ecify)
	ion	nding Ph ath. r: After th e funeral	ation	27. Manner of Death 1 Denotating 28a. Date of Injury (Month, Day Year) 28b. Time of finjury Work? 1 Pending 2 Accident investigation 1 Pending M I Pes 2 No	200. 2000.20	in injury boodined	
	Division	r Atte ler dez recto	ertification:	3 Suicide 6 Could not be determined 28e. Place of figury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or F	tural Route Number,
		urs aft aral Di	O				
		To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier (Check only one) 1 Certifyin Physicien: To the best of my knowled e, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and dua to the nai red at the time, da	use(s) and manner a te and place, and du	s stated e to the cause(s)
_		within To the compl	Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mon	th, Day, Year)
) John & Maria D 25075		Jan 4.	2006
		10		John F. Marra MD 5601 Loch Raven Blue	100.	·	-
	30	Šta	ļ ate	31. Date filed (Month, Day, Year) 32. Restrar's Signature	Dalti	more, MD	21239
		Regist		JAN 0 6 2008 Bear Mr. Market			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer **Physician** THERESA CARSON lan 8:00 AM 02 /Medical 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOS PITAL AGNES NA 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Yrs. 225.12.1181 91 Director Usual Residence of Decedent 10a, State 10b. County Show 10c. City. Town or Location 10d. Inside City Limits ns 23a or 28e-f shor 1 Yes 2 No Director MD BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 HOLLY ROAD MANOR 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give r then "netural", or items tre Medical Examiner ma Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 2 No Specify: Completed by Specify: BLACK 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 TH GRADE CLERK NA US POST OFFICE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WALLEY PARROT EMMA ALFORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f of Health THERLO BRISTOW SON 306 HOLLY MANOR other t CATONSVILLE MD 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 Burial 2 □ Cremation 3 □ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) MD. NATIONAL 01.07.06 LAUREL, MD 22. Name and Address of Facility
VAUGHN C- GREENE FUNERAL SERVICE
15151 BALTO. NATE PIKE BALTO. MO 21229 21. Signature of Funeral Service Licensee Vaughn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HEART disease or condition resulting in death) ATTACK /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underwing Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death ed by the a detached f 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 ☐ Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1X Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No the 2 Accident Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

requires that the death certificate be executed 68760, P.O. Division of Vital Records, death filled in by ō within 24 hours a

Maryland 21215-0036

Baltimore,

10 State

Registrar

31. Date filed (Month, Day, Year)
JAN 0 5 2006

29b. Signature and title of certifier



32. Registrar's Signature

29c. License number

(0002100)

29d. Date signed (Month, Day, Year) Jan 02, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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P. C. C.

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BALTIMORE, MD

			. For	State of Marylar	nd / Department of I		•	•	00025
			1 - State Registrar		Certificate of	Death	Reg. N	6.000	00023
	Physici	an	1. Decedent's Name (First, Middle, Last)	Coat	es		2. Date of Death Month D	ay Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			or Location of Death	MANGRAY .	2 2006 lc. County of Death	39.38 **
		•	University Sp	ecialty Ho	spital Ba	Itimo	re	NA	-
	Funeral Director		5. Social Security Number 6. Security Number 6. Security Number 10. Security Numbe	7. Age (In yrs.	last birthday) If Under 1 Year Yrs. Months Days		8. Date of Birth		110 110 -
	ש		Usual Residence of Decedent				much ale	7, 5, 7	arylana
	show	ō	10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	r 28a-	Director	10e. Street and Number		10f. Zip Code		10g. C	Citizen of What Cour	ntry?
	ath with	ralD	1702 Ruxte	on Ave.	213	216		USF	1
	ter de	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	I.S. 13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
9036	ours af	l by I	3 ⊠Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify: R	ack
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Maryland	should nd Men marke umatic	^L	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailing Address (Street	t and Number or Ru	a COCh	Or Town State Zin	c Code)
	and 2 sealth ar n 27 is		Mr. Robert	Little Sr	751 W.Sa	ratoga	St.	Balto.	Md. 21201
ore	Pages 1 and of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		Place of Disposition (Name of cemetery, crematory or other pla			Location - City or To	own, State
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	Physician / /Medical	Š.	Immediate Cause (Final disease or condition resulting in death)		Nr FAILU	ut			Two weeks
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Box	death e atten	ician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 Ectopic pregnanc	y .		23d. Date of delive Month	Day Year
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Division	after c Direct Tin by	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory, office fy)		28f. Location (Street a City or Town, Sta	and Number or Rura ite)	il Houte Number,
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		(Check only 2 Medical Exemi	ner: On the basis of examina	owledge, death occurred at the ti ation and/or investigation, in my	me, date and place, opinion, death occur	and due to the cause(s) and manner as sind place, and due to	tated.
	o the vithin 2 o the omplet	Medical	one) 29b. Signature and tiple of certifier	and manner stated.	29c. Licens			ate signed (Month,	
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	H		30. Name and address of person who co	mpleted cause of death (Iter	DO(123a) (Type, Print) 15 307 84	4	1,10	2:005	
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	Registr	ar	JAN 0 5 200	6 Marian	2 Acquest				

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ore	of Hee		20a. Method of Disposition 1☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	metery, crer	sition (Name of natory or other plac		Date		ation - City or To	own, State
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Baltimore,	Definit. rages Department of Important: If it eny injury or o		21. Signature of Funeral Service Licen	500	122 14	R. Name and Address ARTLEY MI	ss of Facility	Tella Fui	recal	Home C	470.
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			For State Registrar		State of N	Marylan		artment of H		d Menta	l Hygie	600	6	00027
	Dhysisi		1. Decedent's Name (First, N	liddle, Last)			-			2. Date Mor	of Death	Day	Year	3. Time of Death
į,	Physici /Medic	· .	John				_Co	vey		7	Dynair	12,2	coic	0730AM
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			5. Social Security Number	S Bay	view Man		last birthday)	Baltimo	If Under 24 I	174 Hrs. 18 Day	e of Birth		O Rinth	place (State or Foreign
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and	d a a	Be	John Cavey	.0.0, 2201)						ne Ger		2011 021114111	7	
Maryland 21215-0036	E B B E	ပ	19a. Informant's Name/Rela	tionship (Typ	se, Print)		19b. Maili	ng Address (Street	an <i>d Number</i> o	r Rural Route	Number, C	ity or Town, S	State, Zij	Code)
	nd 2 lith a 27 ls		John Cavey				2901	Harview	Avenue	Balti	more,	Mary1	and	21234
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-60			23a. Part1. Enter the diseas shock, or heart failure	e of complic	ations that cause cause on each	ed the deat line.	h. Do not en	er the mode of dyin	ig, such as car	diac or respir	atory arrest			Approximate Interval Between
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Division	i or Attendi after death. Director: A I in by the fu	Certification:		etermined	28e. Place of building,	etc. (Specil	ome, tarm, st fy)	reet, factory, office			or Town, S		r or Hur	al Route Number,
_	spital ours		29a. Certifier 1 Cer	tifying Phys	ician: To the be	st of my kno	owledge, deal	h occurred at the tir	me, date and n	lace, and due	to the caus	e(s) and mar	ner as	stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	Medicai				of examina		vestigation, in my o						
	withir. To th	Me	29b. Signature and title of ce	ertifier				29c. Licens	e number		29d.	Date signed	(Month,	Day, Year)
			Eley 11	a	long			BES-	-000		Ja	nuary 3	1,20	006
•	4		30. Name and address of pe	rson who co	mpleted cause of	of death (Iter	п 23а) (Туре	Print)						more
	1		Elizabeth Co	mepa	Johns +	topking	Bayo	iew Medic	al Cenk	1, 4941) Eask	in Ave,	Man	pland 21224
. Sy	St Regist	ate a	31. Date filed (Month, Day,	,	A ST	strar's Signa	ature							
	riegist	1 421	JAN	0 5 20	DE Me	7	FE PL	SCARL!						

		State of Maryland / Department of Health and M State Certificate of Death		2000	00028
Physicia	in	Decedent's Name (First, Middle, Last)	2. Date of Dea	Day Yes	
/Medic Examine	ai	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of D	
Examili	ÇI	GENESIS BRIGHTWOOD CENTER LUTHERVIL			MORE
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Da	y, Year) 9.	Birthplace (State or Foreign Country) MARY I AND
and	ĺ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
death with the Maryland ma 23a or 28a-f ehow frank be notified at	ţō	MD BALTIMORE BALTIMORE			1 Yes 2 Ne
ih the or 268	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
ath wi		2930 GRENDON LANE 21234		USF	+
affer death w	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 1 7 ss 2 No	pecify Yes or No- p Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
036 ours al	۾	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates: /943-45 1□ Yes 2 ☑ No Specify:		Specify:	JHITE
21215-0036 ad within 72 hours after rigiene. er then "natural", or ite er then "natural", ur ite Modical Exeruits.	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work done	king	16b. Kind of Busine	
withir then	dwo	Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT		COUFER	
laryland 212: 2 should be filed within and Mental Hygiene. is marked other then sumatic event, the Mental Hygiene.	Be C		ne (First, Middle,	Maiden Sumame)	men
arylandshould be and Mental smarked ourmatic even	To E	CLARENCE COX GERM	FROINE	- KEAS	E
ire, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other then "natural", or itema 23a or 28a-f eho other traumatic event, the Madical Exacultational be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rui	0		1000
ore, M		20a. Method of Disposition 20b. Place of Disposition (Name of	Date P	20c_Location - City	10m M1) 21093 or Town, State
Pages nent of I the			loos	PARKUI	
를 등등등을			LANS OF	UNERAL	
Dep Con Con Con Con Con Con Con Con Con Con	_	Lotato Sulatone & 8800 HARFORD	es. Par	KuillE, M	
Physician		23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS	or respiratory ar	rest,	Approximate Interval Between Oaset and Death
/Medical Examiner		Due to (or as a consequence of):	/ . 0	, [
The state of	ē	SACRAL DECUBITUS ULCRA/ planting to immediate cause. Enter Underlying Due to (or as a consequence of):	INFE	red	USERKS
P M 760, 760, 150, 150, 150, 150, 150, 150, 150, 15	Examine	Cause (Disease or injury that initiated events c.			
50, 50, ce exe		resulting in death) Last Due to (or as a consequence of):			
O 88 O	dicai	d			
Box 6	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of	delivery
11 . 2	sicla	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
		9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	220 Did to	bassa usa saabibuta	to the course of death ?
To R S PE	d by	Tarti. Site of significant solutions commoduling to dealin but not resulting in the underlying cause given in Farti.			to the cause of death? Probably 4 Vunknown
ecorc law requi	ompieted		24a. Was a	an 24b. Were	autopsy findings available
Rec The lav	Com		autop: perfor	med? death	o completion of cause of ? es 2 No
/ita	Be	25. Was case referred to medical examiner? 26. Place of Deat	th (Check only or	nel	
2 1	2	1 Yes No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Ho 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ence 6 Other (S	pecify)
Vision o	ation	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	Zod. Describe ii	ow injury occurred	
A (C) (Division or attending affer death. Director: Alte	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	edical C	29a. Certifier (Check only one) Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and manner stated and place, and manner stated.			as stated. ue to the cause(s)
To the vithin :	Me	29b. Signature and title of certifier 29c. License number	- 2	9d. Date signed (Mo	nth, Day, Year)
		Hendale Walley D25643		01/03/	and I
1041	Ì	29b. Signature and title of certifier 29c. License number	111.	202/0	althere ID 21204
10,		Hendall 12 - author MD/ 6565 N. Charles Street 31. Date filed (Month, Day, Year) 32. Significants Signature	T/ Scut	2003/10	altriere
Stat Registra		JAN 0 3 2006		VV	10 0100

		State of Maryland / Depart State Registrar State Of Maryland / Depart Certification	tment of Health and N ficate of Death	Mental Hygien	2000 00022
Physici		1. Decedent's Name (First, Middle, Last) HELEN ANITA COATNEY		2. Date of Death	3. Time of Death 9:00 a M
/Medio Examin		1010 MAPLE HURST LANE	b. City, Town, or Location of Death	4	4c. County of Death BALTIMORE
Funeral Director			If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea NOV • 4,	9. Birthplace (State or Foreign Country) NEBRASKA
Maryland -f ehow	tor	10a. State 10b. County 10c. City, Town or Locat MD BALTIMORE MONKTO			10d. Inside City Limits 1 ☐ Yes 2 🏋 No
h with the M 23s or 28s-f	al Director	10e. Street and Number 1010 MAPLE HURST LANE	10f. Zip Code 2 1 1 1 1		Citizen of What Country?
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28s-f show event, the Medical Examinal must be notified at	by Funeral	Amed Forces? If You have Married 2 Married 1 Yes 2 No	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto] Yes 2 X No Specify:	pecify Yes or No- c Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
od within 72 hours glene. er then "naturel", the Wedical Exc.	Completed	(Specify only highest grade completed) (Give kin	nt's Usual Occupation of of work done during most of work NOT use retired) AKER	king	Kind of Business/Industry
	To Be (17. Father's Name (First, Middle, Last) HANS IVERSEN		ne (First, Middle, Maid HERINE HA	•
2		CATHERINE WAGNER daughter 1010		LANE, MO	y or Town, State, Zip Code) NKTON, MD 21111
Pages nent of nnt: if it ury or o		1 V Burial 2 ICremation 3 x Bernoval from State	tory or other place)	Date 20c. / 05/06 DA	Location - City or Town, State
Deputition of the point of the			lame and Address of FacilityHEN		NKINS & SONS CO. MD 21111
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition.	the mode of dying, such as cardiac	or r spiratory arrest,	Approximate Inter 1 Between On 1 t and Death
/Medical Examiner		resulting in death) Die to a sa consequence of): Sequentially list conditions, b. 2	liverticalis	Pis	Zuenthe
sate be executed shysicien and the burial-transit	dical Examiner	if a my loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	1000 EUM 00102-0 M		
DIVISION OF VITAINEEDINGS, F.O. BOX 00100, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi		ctopic pregnancy other (specify)		23d. Date of delivery Month Day Year
requires that been signed be should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		o use contribute to the cause of death? 2 🔄 📆 o 3 🗀 Probably 4 🗀 Unknown
The law receive hes bee	Completed	osteoporosis, seve	°TQ_	24a. Was an autopsy performed?	
Of VICAL Physician: rthis certifice ral director, p	o Be	25. Was case referred to médical examiner? 1 ☐ Yes 2 ☐ Mo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Othor	th Check only one ome 5 Residence	C = 00 to - 1 (0 - 1 + 1)
nding Phy ath. r: After this	H-	27. Manner of Death 1 Patural 5 Pending 2 Accident Investigation 28a. Date of Injury 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	
the Hospital or Attending in 24 hours after death. the Funeral Director: After mpletely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street building, etc. (Specify)	t, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
he Hospi in 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one) 1. Lertifying Physician: To the best of my knowledge, death of the basis of examination and/or investigation and manner stated.	ccurred at the time, date and place, stigation, in my opinion, death occu-	, and due to the cause rred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To t Comp	Σ	29b. Signature and title of entitle	29c. License number	29d. (Date igned (Month, Day, Year)
1		30. Name and address of Jerpon who completed cause of death (Item 23a) (Type, Pri	7. Carrenal 1	RI D.	12/06 Just Ton MT 11/20
St Regist	ate rar	31. Date filed (Montl), Day, Year) 32. Registrar's Signature	de la	-4 /0	man j

			For State Registrar		•		d / Depa	irtment of tificate of	Health a	and Men	ital Hygi	•	6	00030
	Physici		Decedent's Name (First ALBERT	t, Middle, Last) T	1		CES	KY	-		Date of Death Month	Day	Year 06	3. Time of Death 4:50 P M
	/Medid Examin		4a. Facility Name (If not ii			ber)	OLD.		n, or Location		<u> </u>	4c. County		
	Examin	eı	FOREST HILL	HEALTH	& REH	AB		FORES	T HILL			HAR	FORD	
	Funeral Director		5. Social Security Numbe 220-05-0161		M 2□F	7. Age (In yrs. i 86	last birthday) Yrs.	If Under 1 Ye Months Da		Min.	Date of Birth (Month, Day, pt. 20	(ear) 1919	9. Birtho Cour Mar	place (State or Foreign http: yland
	and W		Usual Residence of Dece 10a. State 10b.	County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
:	e Maryli 36-1 sho	Director		Harford				ngsvill	e					1 ☐ Yes Ž☐ No
:	or 24	Dire	10e. Street and Number					10f. Zip Cod				g. Citizen of \	What Cour	ntry?
	s 23s	rai	805 Karylou		2 W D	don't Coming III	6 100	210		ining (Consider		J.S.A.	Amori	can Indian,
9	s after de , or Item scolcer	y Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 D	2☐ Married	Armed For 1 FYes : If Yes, Give	2 □ No	1	Vas Decedent of fYes, specify C I□Yes 2덨[in, etc.)	Blac	ck, White,	etc.
3	hour fure	ed b	X	Decedent's Educa	Year or Da	ies:	16a Deced	ient's Usual Oc	cupation		1	6b. Kind of B	usiness/In	dustry
0000-01717	within 72 ane. than "ne	Completed by	(Specify on Elementary/Secondary	ly highest grade	completed) College (1-	4or 5+)	(Give	kind of work do DO NOT use re:	ne durina mos	st of working		home i		
yiana z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department: If tier at 1s marked other than "naturel", or flems 23e or 28e-f show eny injury or other treumatic event, It a Marylan Examination and page. Examination of the provided and page 1. The Marylan Examination of the provided at the page.	Be	12 years 17. Father's Name (First,							er's Name <i>(Fi</i>	rst, Middle, M.	aiden Suman	ne)	
Š	hould d Mei mark matic	2	Frank Cesky 19a. Informant's Name/P		e Print)	·	19h Mailir	ig Address (Str				City or Town	State Zir	Code)
<u>0</u>	treum		Kimberly Ma			ghter		lunters						
5	s 1 ar f Hea item other	١.,	20a. Method of Disposition	n		20b. P	lace of Dispo	sition (Name or natory or other	olace)	Date	2	Dc. Location -	City or To	own, State
Ē	Page nent o nt: If ry or		1 □ Burial 2 🖔 Cre `4 □ Donation 5 □ 0		moval from S			Cremato		1/5/06	В	altimo	re, N	1d.
baltimore,	permit. Departr Importe eny Inju		21. Signature of Funeral	Service Licensee	اعدو	عب	22	Schimus						
-	73.5		23a. Part1. Enter the dis	ease, or complic	ations that ca	used the deatl	h. Do not ent							Approximate Interval Between
	Physician / Medical / Medi	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition from the cause. Enter Underlying that initiated events resulting in death) Last	ns, alle b.	Due to (d	or as a conseq	uence of): uence of):	rtize	hum					Onset and Death
100	certificate be e nding physiciar ise as the buria	icai	IF FEMALE:	d.	c If ves out	come of pregna	ancy					22d Da	to of dollar	
<u> </u>	death e atter id for u	Physician/Med	23b. Was decedent preg in the past 12 mont 1 Yes 2 No 9 Unknown	nam	1☐Live bi	nth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pregna Other (specify					te of delive onth	Day Year
ras, r	es pe	by	Part II. Other significant	conditions cont	ributing to de	ath but not res	ulting in the u	nderlying cause	given in Part I	1.		cco use cont		he cause of death?
Hec	The taw ete has b page 2 sl	Completed	h								24a. Was an autopsy perform 1 ☐ Yes 2	ed?	Were auto prior to co death? 1 Yes	ppsy findings available mpletion of cause of 2D No
VITA	nysician: Th nis certificete director, pag	Be (25. Was case referred to examiner?								heck only one	-		
5	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ No	Н		npatient 2		it 3 DOA	Other: 4		5 Resider			(y)
	ting After fune	io		Pending	(Monti	f Injury h, Day Year)	28b. Time o		njury at Work? I □ Yes 2 □		Describe hov	v injury occur	180	
DIVISION	or Atten ifter deat Director: in by the	Certification:	2 Accident 3 Suicide 6 [4 Homicide	investigation Could not be determined	28e. Place buildir	of Injury - At h	ome, farm, str	eet, factory, off			Location (Stre City or Town,	eet and Numb State)	er or Rura	al Route Number,
_	To the Hospitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the	edical Ce	(Check only 2	Certifying Physi Medical Examin	er: On the ba	sis of examina								
	To the within 2 To the comple	Med	one) 29b. Signature and title of	of certifier	and mann	or stateu.		29c. Lic	ense number		29	d. Date signe	d (Month,	Day, Year)
	- ≥ i ≥ ∀			0 < 5				7	2 2	2			•	
	'n		30. Name and address of	f person who cor	npleted cause	e of death (item	n 23a) (Tvpe.					Jan 78	C7-	2, 2001
	9		DOV. D 5	2000	~ 6	15 N.	MAC	jha.	R-	e/010				
;; ;;	Sta Regist	ate rar	31. Date filed (Month, Da	ay, Year)	32 A	egistrar's Signa	tyre A	Print) Jha. I						

Amend item 20, pertil, 351, 1/6/00 II

		•	Alien Itali An, perm State State Registrar	of Marylan	d / Depa	artment of H		Mental Hyg	jiene 006	00031
8		15.	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	Physicia /Medic		BEATRICE		DAV	ID		January	4, 2006	3:40 p M
	Examin		4a. Facility Name (If not institution, give street and			4b. City, Town, or		ath	4c. County of D	
- 6			Laurel Regional Hospita			Laurel				George's
	Funeral		5. Social Security Number 6. Sex 1 M 2 T	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, Day	Year) 9.	Birthplace (State or Foreign Country)
¥.	Director			84	frs.			March 2	9, 1921	Rhode Island
7	A		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
Aspen	or 28a-f ehow	ō	MD Prince George	N. T.	urel					1 ☐ Yes 2 ☐ No
9	28a-	Director	10e, Street and Number	з пас	urer	10f. Zip Code		1	l0g. Citizen of What	
dia	Sa of	۵		103		2070	7	of visit	U.S.A	
dic of	78 Z	Funeral	11. Marital Status 12. Was I	Decedent Ever in U.	S. 13.	Was Decedent of Hi	spanic Origin?	(Specify Yes or No-	14. Race - A	merican Indian,
,	E	Fun	1 Never Married XXMarried 1 TY	d Forces? es 2 X∑M No		I Yes, specify Cuba		erto Rican, etc.)		/hite, etc.
5	Exp	þ	3 ☐ Widowed 4 ☐ Divorced If Yes Year	, Give or Dates:		1 ☐ Yes 2 0XNo	Specify:		Specify:	White
G K I K I C-0000	ne fu	Completed	15. Decedent's Education (Specify only highest grade complete	ed)	16a. Dece	dent's Usual Occupa	ation Juring most of w	rorkina	16b. Kind of Busine	ess/Industry
1	- WE	nple	Elementary/Secondary (0-12) Colleg	ge (1-4or 5+)	life.	DO NOT use retired,				
1 7	ygier t.	Co	Grade 10		Hom	emaker			Own Ho	me
	d oth	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,		
7 2	Men	ဥ	Joseph Crompton		T			Patefiel		
2	ie m		19a. Informant's Name/Relationship (Type, Print)					Rural Route Number		
6	Health Pm 27 Ther t		Louis David / spous 20a. Method of Disposition			Ashford	BIVQ.		rel, Mary	
more, w	P P P P P P P P P P P P P P P P P P P		1 Burial 2 XCremation 3 Removal for	om State	emetery, crei	natory or other place		2006		
6	, 눈물을		4 Donation 5 Other (Specify)	West		del Crema				Maryland
	Deparimbo		21. Signature of Funeral Service Licensee	/ 240.05				l Home, P		
10	10200		UZ STA	/ M007				ue Laure		nd 20707 Approximate
			23a. Part1. Enter the disease, of complications the shock, or heart failure. List only one cause	on each line.	n. Do not em	er trie mode of dying	g, such as cardi	ac or respiratory arr	est,	Interval Between Onset and Death
	hysician		resulting in death)	sis						
	/Medical xaminer		Due	to (or as a consequ	uence of):					
	· • • • •	7	Sequentially list conditions D. ———	to (or as a consequ	uence of):					
To to	usit	ulu V	Cause. Enter Underlying Cause (Disease or injury	ngestive H		Failure				
be oversited	n and	Examiner	trial tritiated events	to (or as a consequ						
	physician and the burial-transit	Ca	d. Gas	strointest	tinal :	Bleeding				
The burgoning that the draft goddings	g phys as the	Physician/Medical								
5	andin	S		, outcome of pregna		Ectopic pregnancy			23d. Date of	delivery
ם ק	e ette	lcla	in the past 12 months?	regnant at time of de		Other (specify)			Month	Day Year
) }	by th	hys	9 □ Unknown	nknown						
n i	been signed by the ettending pshould be detached for use as	by F	Part II. Other significant conditions contributing	to death but not resu	ulting in the u	nderlying cause give	en in Part I.			e to the cause of death?
3	been si should	ed ed	Breast Cancer					1 Y	es 2□No 3□	Probably 4 🏋 Known
֓֞֞֜֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	es be	Completed	Diverticulitis					24a. Was a autops		autopsy findings available to completion of cause of
2	page	NO.	Hypothyroidism					perfor	med? deat	ገ ?
פַ פַ	ertific ctor,	Be (25. Was case referred to medical examiner?					eath (Check only or	****	
	r this certificate has trail director, page 2 s	ု	1 □ Yes XX No Hospital:	∑ Xpatient 2 □	ER/Outpatier		4 Nutsing	Home 5 Reside		Specify)
- S	ornera	ino :	27. Manner of Death 28a. D 1 ☑ Matural 5 □ Pending	ate of Injury Month, Day Year)	28b. Time o Injury	Work		28d. Describe h	ow injury occurred	
	leath. Ior: /	catl	2 Accident investigation				Yes 2 □ No			
	olined Direct in by	Certification:	determined 288. P	lace of Injury - At he uilding, etc. (Specify		eet, lactory, office		City or Town	treet and Number o n, State)	r Rural Route Number,
- 1 To	ours a erai l		29a. Certifier 1 滋Xertifying Physician : To	the best of my kno	weledge deat	h accurred at the time	o data and pla	an and due to the o	auco(a) and manna	r on stated
7	within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Examinar: On t	ne basis of examina manner stated.	tion and/or in	vestigation, in my or	oinion, death oc	curred at the time, d	late and place, and	due to the cause(s)
4	rithin Fo th	Me	29b. Signature and utter of certifier	1/1/	. ,	29c. License	number		9d. Date signed (M	onty Day, Year
,	. J		Elich OF	4KGTO	M.L). 100	058	685	1/5	106.
	2		30. Name and address of person who completed	cause of death (Item	n 23a) (Type,	Print)			1//	
	2		Dr. Akoto 344 West Ur	niversity	Blvd.	Silver	Spring,	Maryland	20901	
	∞ Sta			2. registrar's Signa	iture	sele				
	Registr	ar	JAN 0 6 2006	12 36 1350 1	N. M					

			1 - For State Registrer	State of M	/larylan		artment rtificate			nd Me		giene)	16	00032
П	Physici	an	Decedent's Name (First, Middle, I	Last)			D				. Date of Dea	Day,	Year	3. Time of Death
4.0	/Medic	al	Konald 4a. Facility Name (If not institution, g	rive street and numbe	r)			COWN or I	ocation of		anual	4c. Count	2006	17.51PM
	Examin	er	The Volus HI	OKINS H	150,10	31	Ba	Hin	MAR	Dogui	144	N/A		
	Funeral			. Sex 7. A		last birthday)	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. 8	Date of Birt	5,1944		lace (State or Foreign
	Director		218-42-1633 Usual Residence of Decedent	1 X M 2□ F	6	Yrs.					June 1	5,1944	Mary	Tand
	yland how		10a. State 10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside City Limits
	Ba-f si	Director	MD N/A		В	altimo								1 □XYes 2 □ No
	th with th	ai Dire	5409 Gerland A	venue			10f. Zip	1206				10g. Citizen of U.S.A		ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23e or 28e-f show important: If itam 27 is marked other than "natural", or itams 23e or 28e-f show hipty or other traumatic event, the Medical Example at itual be rivillied at ance.	by Funerai	11. Marital Status 1 Never Married 2 Married	If Yes, Give	No No		Was Decedent Yes, spec		panic Origi , Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No can, etc.)	- 14. Rad Bla Specif	ce - Americ ck, White, fv: LIV	etc.
Ö	tural'	ed b	3 ☐ Widowed 4 🂢 Divorced 15. Decedent's	Year or Dates	S:	16a, Dece	dent's Usua	I Occupat	ion			16b. Kind of B	WI	nite
1215	within 72 iene. 'than "na	Completed	(Specify only highest (Secondary (0-12)	grade completed) College (1-4o	r 5+)	(Give	kind of word DO NOT us Barbe	k done du e retired)	iring most	of working	7		ber S	,
Maryland 21215-0036	ild be filed lental Hyg rkad other ic evant,	To Be C	17. Father's Name (First, Middle, La Erminio Denard	'					18. Mother		First, Middle, Ranazz	Maiden Sumai	me)	
Mary	and 2 should salth and Men n 27 Is marka iar traumatic		19a. Informant's Name/Relationship		r		ng Address 9 Ger]					er, City or Town		
altimore,	Pages 1 ar nent of Hea int: If itam iry or othan		20a. Method of Disposition 1 Burial 2 □ Cremation 3		20b. P	lace of Dispo emetery, crei	osition (Nam matory or ot	e of her place)	Das	te	20c. Location	- City or To	wn, State
Ħ,	rtmen rtant: njury		*4 Donation 5 ☐ Other (Spe	cify)	Pa	rkwood	Ceme ⁻ 2. Name and	•		/6/06		Baltimo		•
Ba	permit. Departr Imports any Inju		21. Signature of Funeral Service Lic	Tea (Seat	her C							J. Ruck ore, Man		
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*:	/Medical Examiner		resulting in death)	Due to (or a	as a conseq	uence of):								
	₽ #	iner	Sequentially list conditions, if any, lacking to immodels cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a consequ	uence of								
٧	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	as a conseq	uence of):								
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Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:				Other			Check only o			
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Division	or Attanding after death. I Diractor: Afte I in by the fune	Certification:	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of	Injury - At ho etc. (Specif		reet, factory				f. Location (S City or Tov		ber or Rura	l Route Number,
	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	edicai C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the be caminer: On the basis and manner	of examina	wledge, deat tion and/or in	h occurred a vestigation,	at the time in my opi	e, date and nion, death	place, an	d due to the	cause(s) and m date and place,	anner as si and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	_			29c.	License	number			29d. Date signe	ed (Month,	Day, Year)
}			JE M	•				RES	5-000		7	anuary 1	,200	•
	3		30. Name and address of person wh				_		A4 ~	9120				
	Sta	ite	Joseph Jordan, MD 31. Date filed (Month, Day, Year)	600 North	strar's Signa	iture		اسەرد	, MD	2129	» <i>I</i>			
	Regist		JAN 0 5 3	anne D		y ha	100							

			For State Registrar	State of Ma	arylan		artment of I		nd Menta		en o () (16	00033
			Decedent's Name (First, Middle, I	.ast)		· · · · · · · · · · · · · · · · · · ·				e of Death			3. Time of Death
	Physicia /Medic		ELIZABETH	HOPE	DOV	F.			Jan		Day 02 2	Year 2006	12:00 A ^M
	Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town,	or Location of	Death		4c. County	of Death	, == , 5, 5
			Baltimore Washi				Glen B				Anne	Arun	del
	Funeral Director		5. Social Security Number 226–24–3600	. Sex 7. Ag 1 ☐ M 2 Ø F	e (In yrs. I 81	ast birthday) Yrs.	Months Days		Min. J. Me	e of Birth Inth, Day, Y Ly II,	T924	9. Birthi V11	place (State or Foreign ntry) ginia
	ס		Usual Residence of Decedent										
	anylan show	_	10a. State 10b. County	A d a 1	10c. City	, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 🗹 No
	Ba-f	Director		Arundel	<u> </u>	Pasad							
	h with t	Di	7817 Harbor Road	l			10f. Zip Code 21	122		100	3. Citizen of V	.S.A.	
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heatin and Mentalle Hygiene. Important: if tien 27 is marked other then "natural", or iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Moroced 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	!		Was Decedent of f Yes, specify Cub	oan, Mexican,	in? (Specify Ye Puerto Rican,	es or No- etc.)	Blac	ce - Americk, White,	
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altimore,	ss 1 a of Hea item		20a. Method of Disposition	F-0	20b. Pl	ace of Dispo	sition (Name of natory or other pla	ice)	Date	20	c. Location -	City or To	own, State
Ē	Page ment ant: if ury o		1 Warial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control of the Control				lge Mem.		01-06-06	5 E1	kridge	e, Ma	ryland
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ecc	hesbe pe2sh	Completed							24	a. Was an autopsy		prior to co	psy findings available mpletion of cause of
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O	ding th. Yune fune	tion	1 Natural 5 Pending Accident investigat	28a. Date of Inju (Month, Da	y Year)	Injury 19:00	Wo	rk?]Yes 2⊌N	/	3LCTF	. 1		was con
Division of	f or Attending Petter death. Director: After I in by the funera	Certification;	3 Suicide 6 Could not	ho 1-09	jury - At ho		eet, factory, office		28f. Loc	cation (Stre	et and Numb		Il Route Number.
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	To the Hospitel or A within 24 hours efter To the Funerel Director Completely filled in by	ledicai (29a. Certifier 1 ☐ Certifying (Check only one)	Physician: To the best aminer: On the basis o	f examinat	wledge, death ion and/or in	occurred at the t	ime, date and	place, and due n occurred at th	to the cause time, date	se(s) and ma	anner as s	tated.
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	.1		30. Name and address of person wh	o completed cause of a	death (Item	23a) (Type.		OCME		Jai	nuary	4, 4	JUO
	7		MARGAMON A	ICONOU			111 Per	nn Stre	eet Bai	ltimo:	re, Ma	ry1ar	nd 21201
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		1 - For State Registrar	State of Maryland		artment of F ctificate of			ene () () (6 00034
Physici /Medio		1. Decedent's Name (First, Middle, Last) BARBARA	DAVIS				2. Date of Death Month	2 20	ear 6 0315 A M
Examir	er	4a. Facility Name (If not institution, give s NORTHWEST HOSP)				or Location of Death LLSTOWN	1	4c. County of BALT	PIMORE
Funeral Director		5. Social Security Number 6. Sex 216-52-3786	7. Age (In yrs. i	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/04/	1947	Birthplace (State or Foreign Country) MARYLAND
death with the Maryland me 23a or 28a-f show	Director	Usual Residence of Decedent		y, Town or Lo LLA N					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
th with th 23a or 24	ai Dire	7105 CAMPFIELD	ROAD		10f. Zip Code 2120	7	10	g. Citizen of What USA	at Country?
72 hours after death with netural; or Iteme 23a or	by Funeral	11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes X No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. BLACK
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D D -	Be Con	1 2 TH 17. Father's Name (First, Middle, Last)	5 YEARS	MAR	KETING		ne (First, Middle, M	aiden Surname)	PRENUER
0 2 8 g c	2	ALBERT COOK 19a. Informant's Name/Relationship (Ty)	oe. Print)	19b. Mailir	ng Address (Street	DOROT	n Y MOO! iral Route Number,		ate. Zip Code)
G = 64 F		WILLIAM B. DAV	IS/HUSBAND	710	-		, BALTI	MORE CO	O, MD 21207
00		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	1 0	emetery, crer BUTUS	MEMOR I	AL PK 0	1/06/06	BALTI	MORE CO., MD
permit. Page Department Importent: Importent: Importent: Beny Injury o		21. Signature of Europeal Service License	D. Now The	,					HOME 21207 ALTIMORE, MI
Physician /Medical Examiner physician and physician and the price of t	ai Examiner	23a. Party. Enter the disease, or complisations or beart fadure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).	uence of):	er the mode of dyii	ng, such as cardiad	c or respiratory arre	st,	Approximate Interval Between Onset and Death
The control day, T. C. Ed. Dorrificate In The law requires that the death certificate In the hes been signed by the ettending physicage 2 should be detached for use as the India.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di 9 □ Unknown	I death 3	Ectopic pregnanc	у		23d. Date of Month	
uires thet t signed by	þ	Part II. Other significant conditions con	itributing to death but not res	ulting in the u	nderfying cause gr	ven in Part I.			ute to the cause of death?
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To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ition: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 22 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inju	her: 4 Nursing H	ath Check only one dome 5 Resider 28d. Describe how	nce 6 Other	
DIVISION OF All of All	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st y)	reet, factory, office		28f. Location (Str. City or Town,		or Rural Route Number,
To the Hospitel or within 24 hours afte To the Funerel Dir	edical C	29a. Certifier 1 Certifying Physical Chack only 2 Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat ition and/or in	h occurred at the to vestigation, in my	ime, date and place opinion, death occu	e, and due to the ca urred at the time, da	use(s) and manr te and place, an	ner as stated. d due to the cause(s)
To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certifier	in Maria		29c. Licen	se number	29	d. Date signed ((Month, Day, Year)
11		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type.	Print)	7. 1010		-Was	11,006
St Regist	ate	31. Date filed (Month, Day, Year)	SZ. Registrar's Signa	old C	TI KN	avaanst	wn mu	U1155	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2006 January 3 5:25 A Olive W. Bloodsworth Davies 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Maryland Masonic Home Cockeusville 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 15, 1 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 2 X F 89 1916 217-50-2722 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☑ No Maryland Baltimore. Cockeysville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21030 300 International Circle, Unit 206 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White. Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Church Organist Religious Music 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Clark Wallace Olive Kiniah Insley Andrew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Olive Abt 6601 Marietta Ave., Baltimore, MD 21214 (dauahter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Moreland Mem'l Park Baltimore, Maryland 1/6/2006 `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Stage Demention Immediate Cause (Final End disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23d. Date of delivery Month Day tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No s an opsy formed? 2 X No

Physician /Medical

Physician

/Medical

Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if tiem 27 is marked other than "naturel", or flems 23a or 28e-f show any injury or other treumatic event, ITs Mudical Eracines many injury or other treumatic event, ITs Mudical Eracines many injury or other treumatic event, ITs Mudical Eracines many once.

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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Madrical Certification. To Be Completed by Physician/Medical Examin

Division of Vital Records, P.O. Box 68760,

In

State Registrar

resulting in Gealth Last	d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions of		the underlying cause given in F		tobacco use contribute to the cause of deat Yes 2 □ No 3 □ Probably 4 ﷺUnki	
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25. Was case referred to medical		26. F	Place of Death (Check only	one)	
examiner? 1 ☐ Yes 2 ∑ √o	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Other: 4	Nursing Home 5 Res	sidence 6 Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Ti	ime of 28c. Injury at jury Work?	- A second	how injury occurred	
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fare building, etc. (Specify)	m, street, factory, office		(Street and Number or Rural Route Number own, State)	
29a. Certifier 1 Certifying Ph (Check only 2 Medicel Exenting one)	ysician: To the best of my knowledge, niner: On the basis of examination and and manner stated.	death occurred at the time, dated for investigation, in my opinion	te and place, and due to the , death occurred at the time	e cause(s) and manner as stated. b, date and place, and due to the cause(s)	
29b. Signature and title of certifier	+	29c. License num		29d. Date signed (Month, Day, Year)	

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30.	Name	and addre	ss of p	erson who c	ompleted cau	use of death (Iter	n 23a) (Type, Pi	rint)
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		-	For State Registrar		State of	Marylan		artment of H rtificate of L		d Mental Hy	giene 0 0	6 00036
	Physicia		1. Decedent's Name (First	, Middle, Las	Dan	ahur	2			2. Date of De Month	Day	3. Time of Death
	/Medic Examin								eath	4c. County of		
	Funeral Director		5. Social Security Number 215 – 10 – 851		ex □M 2ÅDF	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Ain. Apr3, I	th 918 M	9. Birthplace (State or Foreign County) Iary Land
	nyland show		Usual Residence of Deced 10a. State 10b.	County		10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, I've Medical Evarithat must be notified at	Funeral Director	Md . 10e. Street and Number	n	/ a		Balti	more 10f. Zip Code			10g. Citizen of Wh	1 (ŽÝYes 2 □ No nat Country?
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5-0036		To Be Completed by Fun	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ D		Armed For 1 Tes If Yes, Give Year or Da	ces? 2 [X]No ∋		f Yes, specify Cuba 1 ☐ Yes 2🗓 No	Specify:	uèrto Rican, etc.)		White, etc. White
1215-0			(Specify only Elementary/Secondary	3	ducation de completed) College (1-	4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of)		16b. Kind of Busi	
1d 21	e filed within II Hygiene. other than "		8th 17. Father's Name (First, i	Middle, Last)			Ass	embly L		Orker Name (First, Middle,	Sho	
Maryland 2121	2 should be and Mental is marked o		James Kal	Lisza			10b Mailir	Address /Street		ia Weber		to to Zin Codo)
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Baltimore,	permit. Pages 1 and Department of Heall Important: If Item 2 any injury or other 900ce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crer 4 ☐ Donation 5 ☐ C	nation 3 [y)		emetery, crer Star		em. Ja			re, Maryland ral Home,PA
Bal			21. Signature of Funeral S	Mad	nd		1	201 Dun	dalk A	Avenue B	altimor	e, Md 21222
	The law requires that the death certificate be executed The law speed signed by the attending physician and sage 2 should be detached for use as the burial-transit		23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition	ease, or com re. List only	plications that ca one cause on ea	used the death	n. Do not ent	er the mode of dying	g, such as çard	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
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Box 6		Physician/Mec	IF FEMALE: 23b. Was decedent pregnin the past 12 month 1 □ Yes 2 ☒ No		4□Pregna	rth 2 □ Feta ant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	,
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on o	Attending Physician: r death. ector: After this certifica by the funeral director, p		27. Manner of Death 1 Natural 5 2 Accident	Pending investigation		f Injury n, Day Year)	28b. Time of Injury	Work	at ? ∕es 2 □ No	28d. Describe h	now injury occurred	
Division	Hospital or 4 hours afte Funeral Dir. ely filled in I	Certification:		Could not be determined	288. Place	of Injury - At ho ig, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (5 City or Tox		or Rural Route Number,
		Medical (29a. Certifier 1 0 (Check only 2 N one)	ertifying Ph ledicel Exen	ysician: To the niner: On the ba and mann	sis of examina	wledge, death tion and/or in	n occurred at the tim vestigation, in my op	e, date and pl inion, death o	ace, and due to the courred at the time,	cause(s) and mann date and place, and	ner as stated. d due to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of	certifier			1	29c. License	number		29d. Date signed (Month, Day, Year)
	1		30. Name and address of	person who	completed cause	o of death-(frem	23a) (Type,	Print)	62650	7 / 1	1/3/06	2
	Sta	te	31. Date filed (Month, Day	** * *	Lan Ka	ogistrar's Signa	ture &	Hudsen-	17. 13	ald your,	MD + 1+3	7
	Registi	ar	J	AN 0 4	1 2006	Electrica	Ar 1	Maria Cara				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** January 1, John Junior Duffey 2006 12:07 A^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7975 Crain Highway Apt. 420 Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JAN 31, 1 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 214-20-8793 79 Yrs. Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits worde i rthen "natural", or items 23a or 28e-f ehov Tre Medical Evantrar must be notified at MD 1 ☐ Yes 2 👿 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7975 Crain Highway, Apt. 420 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:1946-1947 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Importent: if Item 27 is marked other the eny injury or other traumatic event, Item 2016. Clerk 12 U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Duffey Florence May Sullens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Thomas P. Duffey, son 6182 Fairbourne Ct. Hanover, MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 01/02/06 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a METASTANC RIAME CITLL CARCINOTA MUNDA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the ettending physicien and detached for use as the burial-transit be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) 1027838 JANIUMY 2, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Outre SITAMINS, M.O SISCATO DIDON RO LINIDALUS, MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State The was St. JAM 0 3 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem 1 per doc 8511 6 06 vt. State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LINDA **IRENE** 2, LINDA IRENE EDELIN EDELEN **JANUARY** 2006 A M 2:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS ELDERCARE - HAMMONDS LANE BROOKLYN ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F 53 Director 216-60-9894 1952 MARYLÁND 6, Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits LANSDOWNE 1 ☐ Yes 2 No MARYLAND BALTIMORE COUNTY Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2918 HAMMONDS FERRY RD. 21227 UNITED STATES by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify Specify: 3 ☐ Widowed 4 X Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) AQUILLA JAMES GRAFTON 2 BETTY WHALEN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Importent: If Item 27 is any injury or other treu 2002. TAMMY DISCUS / DAUGHTER 201 THREE CREEKS DR., CENTREVILLE, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition JANUARY 3 20c. Location - City or Town, State 1 □ Burial 2 X Cremation 3 □ Removal from State ` 4 ☐ Donaston 5 ☐ Other (Specify) METRO CREMATORY, INC. 2006 CATONSVILLE, MARYLAND 21. Signat e of Cheral Service Licensee 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rechal **Physician** Metastatio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Mulnknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 💆 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No Certification: To 2 ER/Outpatient 3∏ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records, Hospitel or Attending Physicien: death. To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "naturel", or Ite

Baltimore, Maryland 21215-0036

completely 4 State

Registrar

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

JANUARY 3, 2006 D-53462

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7845 OAKWOOD RD., SUITE 100, GLEN BURNIE, MD 21061

MD

JAN 0 3 2006

title of

ertifier



			for State	State of Maryla		ent of Health and cate of Death	Mer		200	6 00039
			Registrar 1. Decedent's Name (First, Middle, Last)		Certinic	ale of Death	2.	Date of Deat	ig. No.	3. Time of Death
	Physici		le court	tonou d	Ende :	IR		Month SANUAI		eer
	/Medic Examin		4e. Facility Name (If not institution, give s	treet and number)	4b.	City, Town, or Location of Dea	ath	MIN CITY	4c. County of	
			3904 BOXWOOD	1 Kd		Farretts vill	le		Harf	ord.
	Funeral		Social Security Number 6. Sex	7. Age (In yrs	— C Mor	Inder 1 Year If Under 24 Hi		Date of Birth (Month, Day,	Year) 9	Birthplace (State or Foreign Country)
g.	Director		Usual Residence of Decedent	- C	Yrs.		(0-11-	47 P	MARYLAND
jand	A =		10a. State 10b. County	10c. C	ity, Town or Location	1				10d. Inside City Limits
May	9	tor	Mrs Hactor	d	Jac	reltsville				1 ☐ Yes 2 No
th the	or 28	Jirec	10e. Street and Number	1	10	f. Zip Code		10	Og. Citizen of Wha	at Country?
ath w	23a	Funeral Director	3904 BOXWO	nd troad		21084			USH	+
er de	Itam	une	11. Marital Status 1 □ Never Married 2 Married	2. Was Decedent Ever in t Armed Forces?		ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue	(Specify arto Rica	Yes or No- an, etc.)		American Indian, White, etc.
S aft	al', or itama 23a or 28a-f shov Exeminer must be notified at	by F	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 🗆 Y	es 21 No Specify:			Specify:	1) hite
III K I K I S-0000 be filed within 72 hours after death with the Maryland	natural, or itama 23a or 28a-f show olical Examiner must be notified at	ted	15. Decedent's Educ	ation	16a. Decedent's	Usual Occupation		1	16b. Kind of Busin	ess/Industry
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42.5	Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "naturenty injury or other traumatic avant, It a Modical pros.		19a. Informant's Name/Relationship (Typ	1 () D	20011 P	dress (Street and Number or	HUI'AI H	oute Number,	Lity or Town, Sta	ate, Zip Code)
1 and	Heal tem 2 other		20a. Method of Disposition		Place of Disposition	(Name of	Bate	Jarre	20c. Location - Cit	y or Town, State
Pages	t: If i		1 M Burial 2 ☐ Cremation 3 ☐ Re 1 M Donation 5 ☐ Other (Specify)	moval from State	cemetery, crematory	Or other place)	1.16	C 1	allstan	MO
	Department of Health Important: If Itam 27 any injury or other tr once.		21. Signature of Funeral Service License	9	22. Nam	e and Address of Facility	OPT	OTHI	LI, MO	21050
3 8	Depa Impo eny ir		Kinberly U.	aunotitus	FVAN	IS FUNSRALCH	HAPI	FL-BFI		SELV PORTUR.
7			23a. Part1. Enter the disease, or compile shock, or heart failure. List only on	ations that caused the dea	th. Do not enter the	mode of dying, such as cardi	ac or re	spiratory arre		Approximate Interval Between
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C P	endin r use	Physician/Me	23b. was decedent pregnant	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		pic pregnancy			23d. Date of	
9 9 9	the att	sici	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time of 9 Unknown		r (specify)			Month	Day Year
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ires t	signe d be c	1 by	Paren. Diner significant conditions com	ributing to death but not re	sulting in the underly	ing cause given in Part I.				te to the cause of death? Probably 4 Unknown
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Hose	Fune Fune	edical	(Check only 2 Medical Examin	er: On the basis of examin	ation and/or investiga	rred at the time, date and placation, in my opinion, death occ	curred a	t the time, da	te and place, and	due to the cause(s)
To the Hospitel or Attending	within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Med	29b. Signature and ritle of gertifier	and manner stated.		29c. License number		29	d. Date signed /M	fonth, Day, Year)
ř	š⊢ŭ		A Louge	allam	M.D	DAGEZ	0	1	21-03	-2006
	0,		30. Name and address of person who cor	npleted cause of death (Ite	m 23a) (Type, Print)				1 0 3	2000
	1		S. SWASAILAM	60a 5 At	wood	oad, Snite	2	00, F	Belau	21014
. J.	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 6 2001	32. Registrar's Sign	ature description	29c. License number D 4553 and, Snite				

Amend item#20, perfo, 0851, 1/6/06 II Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician Linda Edwards January 2006 5:27 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harbor Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 X F 212 60 7179 Yrs. 50 14, Director Oct. Marvland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Marvland Directo Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with I n and Mental Hygiene. Is marked other than "natural", or Items 23a or 2 21225 8 Thomas Avenue U.S. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bartender 12th Racetrack 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I Donald Robert Wilt Delores Sherwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6601 Polynesian Lane Glen Burnie, Maryland 21060 item 27 Dawn Edwards / Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State artment of crant: If i 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ö Cedar Hill Cemetery 1/7/2006 Baltimore, Maryland injury ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. e of Funeral Service Licensee Depa Import any ir 4001 Ritchie Highway Baltimore, Maryland 21225 ranusus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. As only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician ATUR /Medical resulting in death) Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of Examiner use as the burial-transit that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I the ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, Be 3 ☐ Probably 4 ☐ Unknown Be Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of eause of death?

1 Yes 2 No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner' Hospital: 1 ☐ Inpatient 2 ER/Outpatient Other: 4 Nursing Home 2 No Certification: To 1 ☐ Yes 3 DOA 51 6 ☐Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 019640 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) HANOVER SNER MO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

2006

	•	State of Maryland / Depa	artment of Health and Mertificate of Death		2000	00041
		Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	J. No.	3. Time of Death
Physicia		Jeanne L. Entwistle		Jan.	2 2006	8:56 P M
/Medic Examin	100	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
		Oak Crest Renaissance Ctr.	Parkville		Baltimo	re
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Bir	thplace (State or Foreign
Director		143-12-5265 1 M 2 X 84 Yrs.		Aug. 3	1921 N.	
and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo.	cation			10d. Inside City Limits
Marylan f ahow	ŏ	MD Baltimore Parkvill	le			1 ☐ Yes 2 No
r 28s	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What C	ountry?
h with		8800 Walther Blvd. Apt. 1609	21234		USA	
ems L	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - Am- Black, Whi	
hours after deeth with the Maryland hours after deeth with the Maryland turel; or Items 23a or 28a-f show all Exeminant he notilied at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ YNo	1 ☐ Yes 2 ☐ No Specify:	,	Specify:	white
72 hours naturel',		3 Wildowed 4 Divorced Year or Dates:	dent's Usual Occupation			
in 72 n na Aeolic	Completed	(Specify only highest grade completed) (Give	kind of work done during most of workin DO NOT use retired)	g	3b. Kind of Business	Middstry
d with giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) 12 Heac	of Sales	Р	harmaceu	tical
be filed within 72 ho Ital Hygiene. Id other than "natu	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name			
2 should be filed within 72 and Mental Hygiene. Is marked other than "net aumatic event, the Medical	ToE	Walter Luyster	Elizabeth	Fowlie		
2 sho and and		19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	ng Address (Street and Number or Rural	Route Number, (City or Town, State,	Zip Code)
Definition of the property of the permit. Peges 1 and 2 should Department of Health and Men Important; If Item 27 is marke any injury or other traumatic once.		John G. Entwistle/husband 8800	Walther Blvd., Ap	t. 1609,	Parkville	MD 21234
Peges 1 nent of H int: If Its iry or ot		Mulburial 2 Ucremation 3 Unemoval from State	natory or other place) 1/6/0	6	c. Location - City or	
t. Pe rtmen rtant:		4 Donation 5 Other (Specify) Dulaney	Valley Memorial Ga	rdens T	imonium,	MD
permit. Depertitional importational sany injury inj		Bryan W. Clary	R. Name and Address of Facility Pmmon Funeral Hom U.W. Padonia Rd.,	ne of Du Timoni	laney Val	ley, Inc.
435V		23a. Part 1 Enter the lisease, or complications that cause of the death. Do not enter shoot, or heart in lure. List only one cause on each line.	er the mode of dying, such as cardiac or	respiratory arres	it,	Approximate Interval Between
Physician	0 1	Immediate Cause (Fin I disease or condition	mid least	1.4	t	Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):	1		,	
LAdiiiiici	la.	Sequentially list conditions, b.	July 25 cm + V	anns	10	
ped jisc	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•			
be executed ician and burial-transit	xan	that initiated events c				
cate be exphysician the buria	dicai E					
ifficate g phys as the	edic	u.				
The law requires that the death certificate be executed are hes been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1]Ectopic pregnancy		23d. Date of de	livery
ne deat the attr	sicia	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
that the deathed by the atte	Phys	9 Unknown				
signed t	ρ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.			o the cause of death?
w requir	ted			1 L Yes	2 No 3 P	robably 4. Striknown
e law hes b	ompieted			24a. Was an autopsy	24b. Were a prior to	utopsy findings available completion of cause of
: The	ပ္ပ			performe 1 Yes 2 ∫	ed? death?	2 □ No
ician: The	Be	25. Was case referred to medical examiner?	26. Place of Death			
Phys ral dir	- To	1 Inpatient 2 EH/Outpatien	Nursing Hom	e 5 Residen	ce 6 Other (Spe	ocify)
Attending Physician: The advanture of death. Solder this certificate he by the funeral director, page	tion	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) Injury 28b. Time of Injury	28c. Injury at Work? M 1 \(\text{Yes} \) 2 \(\text{No} \)	od. Doscribe non	injury occurred	
Attenda r dea octor	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str.			et and Number or R	ural Route Number,
s afte	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	
Livision of the Hospital or Attending Physician: within 24 hours after death of the Funerel Director. After this certifical completely filled in by the funeral director.	Medical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	h occurred at the time, date and place, as vestigation, in my opinion, death occurre	nd due to the cau d at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
o the vithin o the omple	Me	29b. Signature and title of certifier	29c. Excense number	290	d. Date signed (Mon	th, Day, Year)
->F0		12 Adland ill	1 24742		13/06	
10		30 Name and address of person who completed cause of death (Item 23a) 17 e,	Print)	0. 1	Jan Mar	21234
Sta		31. Date filed (Mchrift Playn Year) 2006 32. Registrar's Signature	- (100 () (V)	ink	THE MAN	40.1
Registr	rar	JAN 0 3 ZUUS JAN STEEL SE AME				

Entwistle

J econe

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Year **Physician** 12-44AM lan 00% /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, You Oct. 27, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . 1958 **Funeral** Days Hours 1 □ M 2 X F 47 Yrs. Director 220 84 8449 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Items 23a or 28e-f show the Medical Examiner must be notified at Maryland 1 ☐ Yes 2X No Director Howard Ellicot City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9746 Michaels Way 21042 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 內 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours atter arment of Health and Mental Hygiene.
ortent: If Itsm 27 Is marked other then "neturel", or Ite injury or other treumatic event. Ihu M. C. Eal Examina. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard French Marjorie Prince 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greg Welsh / Cousin 1508 Lochaber Court Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or ance. Glen Haven Mem. Park 1/7/2006 Glen Burnie, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee a, or supplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ust only one cause on each line. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, shock, or heart failure. L Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Die to (or as a consequence of **Examiner** UMONIT Sequentially list conditions Examiner dany leading to immedicause. Enter Underlying Cause (Disease or injury or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part IJ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 2 No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 🗆 Yes 2 No 1 🗂 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death completely filled in by the 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours af To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State	State of Maryla	and / Dep	artment of H	lealth a	and Mental Hy	9	6	nn1.3
			Stete Registrar 1. Decedent's Name (First, Middle, La	ne1	Ce	rtificate of	Death	2. Date of De	Reg. No.		3. Time of Death
	Physici /Medic	al	EDWARD	NE	IL	FRE		JANUARY	I 200) ^{Year}	3:00 P M
	Examin	er	4a. Facility Name (If not institution, giv			4b. City, Town, o		of Death	4c. County	of Death	
	Funeral		6707 GREENSPRING 5. Social Security Number 6. S	ex 7. Age (In)	rs. last birthday,	If Under 1 Year	If Under		h	9. Birthp	place (State or Foreign
	Director		213-58-8616	X M 2□ F 5	8 Yrs.	Months Days	Hours	Min. 09/18/1	947	Cou	D.C
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation					10d. Inside City Limits
	Aaryla I eho	ō	MD N/		BALTIMO						1 X Yes 2 □ No
	within 72 hours effer death with the Maryland ene. than "netural", or iteme 23a or 28a-f ehow ha Madigal Examiter clust be collified at	Funeral Director	10e. Street and Number	.,		10f. Zip Code			10g. Citizen of V	Vhat Cou	ntry?
	h with	a D	6707 GREENSPRING	AVENUE		21209		to de participa de la companya de la	U	.S.A.	•
	deat	ner	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of H	lispanic Ori	gin? (Specify Yes or No i, Puerto Rican, etc.)	- 14. Raci	e - Ameri	can Indian, etc.
36	or it	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ⊟Yes 2 💢 No If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:		Specify	1	WHITE
21215-0036	hour fural'	ed b	15. Decedent's E	Year or Dates:	16a Dece	edent's Usual Occup	pation		16b. Kind of Bu	ısıness/ir	ndustry
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pu	be file tai Hy d oth	Be (17. Father's Name (First, Middle, Last)	-5-	5 0		er's Name (First, Middle.	Maiden Surnam	Θ)	VAT7
yla	Men Marke Marke	ဥ	LOUIS		FRE		ROS				KATZ
Maryland	permit. Pages 1 end 2 should be filed within 72 hours elter death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or iteme 23a or 28a-1 show entry or other traumatic event, the Madical Examinational be collified at ODEs.		19a. Informant's Name/Relationship (KATI FREED / WII			-		ar or Rural Route Numbe AVENUE - B	-		
	Heal Heal tem 2		20a. Method of Disposition		b. Place of Disp	osition (Name of	Ţ.	Date	20c. Location -		
OL	Pages nent of I ant: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	-	ematory or other pla MUNAH CON		1/02/2006	BALTIMO	RE.	MD
Baltimore,	mit. I pertm portal		21. Signature of Funeral Service Lice		2	22. Name and Addre	ss of Facilit	SOL LEVINS	ON & BR	OS.,	INC.
Ö	Depermination De		Koleto/	Thom		900 REIST	ERST0	WN ROAD - F	PIKESVIL	LE, I	MD 21208
760, 💉 🗚	Physician /Medical Examiner per price and price price representations of the price	ical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		sequence of):	AVZCI NON	n VA				Interval Between Onset and Death () **MM********************************
O. Box 68	the death certifica by the attending pt ached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of produced to the second seco	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Dal Mo	te of deliv	rery Day Year
rds, P.	quires that in signed b uld be det	þ	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause gr	ven in Part I	. 23e. Did t	1		the cause of death? bably 4 Unknown
of Vital Records,	The law requir tate hes been si page 2 should	Completed						24a. Was auto perfo	ormed?	Were auto prior to co death?	opsy findings available ompletion of cause of
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¥ \	Physician: this certific ral director,	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient		STIL 3 DOA		ursing Home 5 PAesi	dence 6 □Oth	er (Speci	fy)
ou c	ing After une	-i-	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time Injury	Wo			how injury occuri	ed	
isio	Attending r death. ector: After by the fune	cat	2 Accident investigated 3 Suicide 6 Could not t	OB Diago of Injury	At home farm s] Yes 2 🗌		Street and Numb	er or Ru	al Route Number,
Division		Certification:	4 Homicide determined	building, etc. (Sp	pecify)	meet, factory, office		City or To		en on 7101	ar noate ivamber.
	To the Hospital or within 24 hours effe To the Funerel Dir completely filled in	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysicien: To the best of my miner: On the basis of exar and manner stated.	knowledge, dea mination and/or i	ath occurred at the ti investigation, in my o	me, date ar opinion, dea	nd place, and due to the ath occurred at the time,	cause(s) and ma date and place,	inner as s and due t	stated. to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier			29c. Licen:	se number		29d. Date signe	d (Month,	, Day, Year)
			1 long			0 30	0377		1/2/0	6	
	12		30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)		100-			
-	1 ,		20.		PAPUL	HEIGHTS	AN	E BRUTIN	wine n	no	51512
4.	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 0 3 20	39. Registrar's S	ignature	will					

			For Stata Ragistrar	State of M	arylan		artment of H			ene g. No.	6 (00044
	Physici	án	Decedent's Name (First, Middle, Las. FLORENCE)		GOI	DVARG		2. Date of Death JANUARY	4, 200	Year 16	3. Time of Death 6:25 A M
	/Medio		4a. Facility Name (If not institution, give	street and number))	GOL		Location of Death	O/MO/MA	4c. County		0.20 //
Am Am	L Adrille		HOSPICE OF BALTI	MORE-GIL	CHRIS	Т		WSON			BALTI	MORE
0	Funeral Director		5. Social Security Number 6. Se 170-01-8306	7. Ag	ge (In yrs. 93	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MAR. 5, 1	Year) 912	9. Birthpla Counti	ace (State or Foreign ry) NY
)06 R	pu *		Usual Residence of Decedent 10a. State 10b. County	••••		y, Town or Lo	cation				10	d. Inside City Limits
4	death with the Maryland ms 23e or 28a-f show rmat be roullied at	tor	MD BALTIN	10RE		•	IMORE				24	1 ☐ Yes 2 🕅 No
7	vith the	by Funeral Director	10e. Street and Number	IN DOED #	000		10f. Zip Code	01000	10	g. Citizen of V	hat Count	
5	eath v	eral	1840 REISTERSTON	12. Was Decedent		S 13 1	Was Decedent of Hi	21208	acify Yas or No-	14 Bace	e - America	USA n Indian
3 ,	after death w	Fun	1 Never Married 2 Marned	Armed Forces? 1 Yes 2 X If Yes, Give	?		Was Decedent of Hi fYes, specify Cuba 1 □ Yes 2 🛣 No	Specify:	Rican, etc.)	Blac	k, White, e	
solar and	Z1Z15-UU30 d within 72 hours after giene. er than "naturel", or Ite y the Wedleel Exercises	ed by	3 Widowed 4 □Divorced 15. Decedent's Ed	Year or Dates:			dent's Usual Occupa		1	Specify 6b. Kind of Bu		
70 2	within 72 see. Than "naile Medic	Completed	(Specify only highest grad	de completed) College (1-4or	5+)	(Give	kind of work done of DO NOT use retired	durina most of work	ing			ustry
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2	ire, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23s or 28s-f show other traumatic event, the Medical Exerts as must be codified at	To Be	BENJAMIN			WOLO	VITZ	JENNIE	o (1 11 31, 1411 2016, 14	aroon Sumatti	0)	BERMAN
en	Mary 12 sho th and I		19a. Informant's Name/Relationship (7	ype, Print) SON			ng Address (Street a		a <i>l Route Number,</i> RANDALLS			
	rre, N s 1 and s f Health Item 27 other tr		20a. Method of Disposition			lace of Dispo	sition (Name of natory or other place			Oc. Location		
1- !	Saltimore Dermit. Pages 1 and popertment of He mportant: If iten any injury or oth		1 ☐ Burial 2 ☐ Cremation 3 🔀 4 ☐ Donation 5 ☐ Other (Specify		1	-	HURUN CEN	1	2006	PITTSE	BURGH,	, PA
-	bail permit. Depert Import		21. Signed to Funeral Service Licen	Sura	re		Name and Address	30	L LEVINS			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cause one cause on each I	d the deat ine.	h. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	cut	e S	troke					weeks
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*	/60, te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseq	uence of):						
	et sys	cal		d								
,	Box 68 leath certificat attending phy for use as the	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Dat	e of deliver	v
d	P.O. BC that the death ed by the atte	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnancy Other (specify)			Mor		Day Year
	rhat the de ted by the detached	y Phy	Part II. Other significant conditions of	ontributing to death t	but not res	ulting in the u	ndertying cause give	en in Part I.	23e. Did tob	acco use contr	abute to the	cause of death?
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-	VITAL RE	e Co	25. Was case referred to medical					00 Blv 4 B v	1 ☐ Yes 2	No 1		2 🗆 No
	f Vita iysician: is certific director.	To B	evaminer?	Hospital: 1 ☐ Inpati	ient 2 🗆	ER/Outpatier	nt 3 DOA Othe	oc	h <i>(Check only o</i> ne ome 5 ☐ Reside		er (Specify)	Hospic
	ng Ph Mfter th	lon:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time o	Worl		28d. Describe ho			112
	DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	-	njury - At h	ome, farm, str	eet, factory, office		28f. Location (Str City or Town,		er or Rural	Route Number,
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	e Hos 124 ho e Fun	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best liner: On the basis of and manner si	of examina	tion and/or in	n occurred at the tin vestigation, in my of	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and ma te and place, a	nner as sta and due to	ited. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	1.0	1 .	.1	29c. License			d. Date signed		
	2		If Hothe	my Mile	La ca	n 22c) (T: -	() ()	7 407		MUN	my "	7, 2006
	13		30. Name and ddress of person who	GBM	C 6	70/ /	1. Chac	les St.	balto	and.	700	7,2006
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ature	e s					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** TAN 03 Mildred D. Gerber 5:30An /Medical 2006 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Futurecare Chesapeake Arnold Anne Arundel If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Director 217-18-5346 Aug. 15.1922 Maryland Usual Residence of Decedent death with the Marylend 10b. County 10c. City. Town or Location 10d. Inside City Limits \$how 7 is marked other than "netural", or items 23a or 28a-f shor traumatic event, the Medical Evandor must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Anne Arundel Pasadena 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 227 Carvel Road 21122U.S.A.

14. Race - American Indian. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: δ 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 8 N/A Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Higdon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis V. Gerber, Jr. (Son) 227 Carvel Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 ☑ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 1/6/06 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE Examiner Due to (or as a consequence of) Examiner attending physician end for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DBSTRUCTIVE PULMONARY DISEASE δ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? END STAGE RENAL DISEASE 1 ☐ Yes 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending efter death. Director: Aft investigation 1 Tyes 2 TNo 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral D 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D57531 , Mi) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mobit Negi, 8601 VETERANS HWY MILLERSVILLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature paren & Speck Registrar JAN 0 4 2006 DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene [] [

1 _ For State

Certificate of Death

Phys /Me Exar

Funer Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important; if Item 27 is marked other than "natural", or Items 23s or 28s-f show sny injury or other traumatic event, the Medical Examiner is untilled at

Baltimore, Maryland 21215-0036

Physicia /Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Hegistrer				001	incate or	Deam		He	g. No.		
cian	1. Decedent's Name	(First, Middle, Last							2. Date of Deatl Month JANUARY	Day	Year OO6	3. Time of Death 4:02 A.M
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al	5. Social Security N			(In yrs. last bir	thday)	If Under 1 Year	If Under		8. Date of Birth		9. Birth	place (State or Foreign
or	216-20-5 Usual Residence of	763	DM 2□F	78	Yrs.	Months Days	Hours	Min.	(Month, Day, 7/31/19)		COL	RYLAND
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Funeral Director	MD	BALTIMO	RE		P	ARKVILLE						1 ☐ Yes 2 🔀 No
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ner	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H	lispanic Orig	gin? (Spec	city Yes or No-		Race - Amer Black, White	
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1		5 Other (Specify		PARKW		CEMETER		1/5/2			MORE,	
OUCE	21. Signature of Fu	neral Service Licens	. //	. /								HOME, P.A.
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	23a, Pinti. Enter the shock, or hear	ne disease, or comp rt failure. List only o	lications that care ed one cause on each lir	the death. Do	not ente	er the mode of dyir	ng, such as	cardiac or	respiratory arre	st,		Approximate Interval Between
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al er	resulting in death)		Due to (or as	a consequence	of):	•						
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an/Medical			d									
Ž	IF FEMALE:		23c. If yes, outcome	of pregnancy						204	Data of data	
	23b. Was decedent in the past 12	months?	1☐Live birth 4☐Pregnant at	2 Fetal death		Ectopic pregnancy Other (specify)	/				Date of deliv Month	Day Year
ls.	1 ☐ Yes 2 ☐ 9 ☐ Unknown	1No	9☐ Unknown		3 _	- Curior (opodiny)						
Completed by Physic	Part II. Other signif	icant conditions co	ontributing to death b	ut not resulting i	n the ur	nderlying cause giv	ren in Part I.		23e. Did tob	acco use co	ontribute to	the cause of death?
d b						, , ,			1 ☐ Ye	s 2 34 6	3 ☐ Pro	bably 4 Unknown
ete									04-146	-	- 14/	
E G									24a. Was ar autopsy perform	ed?	prior to co	opsy findings available ompletion of cause of
										No	1 Yes	2 No
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2	1 Yes 2	NO I	1 Inpatie		utpatien Time of		+ - 110	rsing Hom	-			ify)
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cat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be		As b 6			Yes 2 🔲		04 1 /Cm			10
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	20a Cadifias	19 Continue Div	raining. To the best	-6 (4 1	4.4			
Medical	29a. Certifier (Check only one)	2 Medical Exam	ysicien: To the best of iner: On the basis of and manner sta	examination ar	e, deatr nd/or inv	estigation, in my o	me, date an opinion, dea	d place, ar th occurred	nd due to the ca d at the time, da	use(s) and te and plac	manner as : e, and due t	stated. to the cause(s)
Me	29b. Signature and	title of certifier				29c. Licens	e number		29	d. Date sig	ned (Month,	Day, Year)
	1 hall	- de	170			038	409			1/3/0	6	
	30. Name and address	ess of person who o	completed cause of d	eath (Item 23a)			-					
1	William	Straitma	J. 1075	3 Fall	1 6	こまし	5,6	JMER	112, Ma	1, 2,	AST 3	
State	31. Date filed (Mon	th, Day, Year)	32 Registra	ar's Signature								
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			State of Maryland / Department of Health	•	•	m m m 1 m
		•	1 - State Registrar Certificate of Death	h	2005	00041
E	Physicia /Medic		betty L. Grafton	2. Date of Dea Month	24-2 - 200	3. Time of Death 6. FOP M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location BACGIMORE LOASITINETON MEDICAL CENTER GLEN BI		4c. County of Dea	HZWDE!
	Funeral Director	i i i i i i i i i i i i i i i i i i i		or 24 Hrs. 8. Date of Birtl	9. Bir C. C. Man	thptace (State or Foreign punity)
	Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Clen Burnie			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28a-	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?
	eath w	Funeral		Origin? (Specify Yes or No-	United Sta	
900	hours after death with the Maryland turei', or items 23e or 28e-f ehow al Exactions must be rediffed at	þ	3 ∰ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☒ No Specify	an, Puerto Rican, etc.)	Black, Whi	
Maryfand 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or itams 23s or 28s-f show sumatic event, the Medical Examinat must be recitified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waitress	ost of working	16b. Kind of Business Food Serv	,
מפר	e filed al Hygi other vent,	Be Co		her's Name (First, Middle,		
yfar	ould by Menta	To	e Harry William Whalen Sus	san Marie For		
	D = 5 = 5		19a. Informant's Name/Relationship (Type, Print) Tammy Discus / Granddaughter 19b. Mailing Address (Street and Number 201 Three Creeks I			
Baltimore,	permit. Pages 1 en Department of Heal Importent: if item 2 eny injury or other once.		20a. Method of Disposition 1 🖺 Barial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Jan. 5, 2005	20c. Location - City or	
altin	permit. Pa Departme Important eny injury		4 Dehation 5 Delher (Specify) 21. Signature of Euberal Service Licensee 22. Name and Address of Fact Kirkley-Ruddich 421 Crain Hwy.		Elkridge, N	
	40 E 5 8		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a			21061
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition EAFONIL OSCIPLICATE LUN			Interval Between Onset and Death
420	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
<i>7</i> =	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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687		edical				
O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown		23d. Date of de Month	ivery Day Year
م	uires that the de signed by the a lid be detached f	by	r art ii. Other significant conditions continuing to death but not resulting in the underlying cause given in Part		bacco use contribute to	
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ita	Physician: The la r this certificate has ral director, page 2	BeC	25. Was case referred to medical examiner?	1 ☐ Yes ce of Death (Check only or	2 ☑ No 1 ☐ Yes ne)	2 1 No
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DIX	s after de si Directo ed in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or R. n, State)	ural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical		and place, and due to the death occurred at the time, of	ause(s) and manner as late and place, and due	s stated. to the cause(s)
	To t To t	Σ	29b. Signature inditile of certifier 29c. License number	149	ANUARY	n, Day, Year) 2 2006
	3		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	Glen br	vrne mi	> 2061
Sales Control	Sta Registr		1824 0	J		
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			1- State of Maryland / Department of Health and Mental Hygiene 16 Certificate of Death
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	Examir		4a. Facility Name (If not institution, give street and number) Ab. City, Town, or Location of Death Anne Arvade 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birtholace (State or Foreign
	Funeral Director		219-76-6646 92 Yrs. Nov.20,1913 Kaohsiung, Taiwan
	death with the Maryland ms 23a or 28a-f show I must be notified at	Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Co. Pasadena 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "nature", or Items 23a or 28a-1 show experience in Items 1 and	To Be Completed by Funeral Dir	163 Mountain Road 21122 United States
68760,	Ifficate be executed by Medical Published and Medical Italiansit as the burial-Italiansit	ledical Examiner	23a. Paft/ Enfer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failured List only one cable on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
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	To the Hospitel within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Mo In. Day, Year)
	À		30. Name and address of person who completed cause of death (Item 23a) ype, Print)
	Sta Regist		30. Name and address of person who completed cause of death (Item 3a) ype, Print) Elicott Gorbaty und 141 Mad von Parktine, Genburg, Md, 2061 31. Date filed (Month, Day, Year) 12. Registrar's Signature JAN 0 6 2006

			For State	State	of Maryland		artment of Hetificate of L			giene	006	00049
2	为 ** * * ※		Registrar 1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea		<u> </u>	3. Time of Death
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	/Medic Examir		4a. Facility Name (If not institution				4b. City, Town, or	Location of Deat			2006 ounty of Death	9:30 AM "
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17	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs		1	9. Birthp	lace (State or Foreign
276.	Director		025-14-3457	1 ∑ M 2□F	81	Yrs.	Months Days	Hours Min.	(Month, Day 09/26/		Coun	try)
	D		Usual Residence of Decedent						03/20/	744	rias	sachusetts
	thow	_	10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
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	23s	rail	7910 Redstone	- · · · · · · · · · · · · · · · · · · ·			21087				S.A.	
	sms.	Funeral	11. Marital Status	12. Was De Armed I	cedent Ever in U.S Forces?	5. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (S	Specify Yes or No- to Rican, etc.)	14	. Race - Americ Black, White,	
36	or it	by Fu	1 Never Married 2 Marr	If Yes. C	2 □ No Sive		I ☐ Yes 2 ဩ No	Specify:			necify:	
215-0036	within 72 hours after death with the Maryland ene. than "natural" or items 23s or 28s-f show he Medical Exercinal must be notified at		3 Widowed 4 Divorced		Dates: WW II	10- 0					Whit	
5	d within 72 ho piene. r then "natur the Medical	Completed	15. Deceden (Specify only highe		1)	(Give	ient's Usual Occupa kind of work done d DO NOT use retired)	uring most of wo	rking	16b. Kind	of Business/Inc	lustry
212	withi ene. then	щ	Elementary/Secondary (0-12)	College	(1-4or 5+)					Morci	hant Ma:	rine
CA	Hygi ther int.		17. Father's Name (First, Middle,			De	ck Office		me (First, Middle,			LINE
Maryland	e d al	o Be	Joseph Heroux						anna Sene		•	
<u> </u>	2 should be and Menta is marked reumatic sy	2	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	g Address (Street a				own. State. Zin	Code)
<u>8</u>	od 2 is lith ar 27 is 1 trau	i i	Jeanette K. I		d Eal		Redstone					
ē,	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		20a. Method of Disposition	erous (w	20b. Pla	ace of Dispo	sition (Name of		Date		tion - City or To	
ō	ages int of t: if if		1 Burial 2 Cremation		n State	metery, crer	natory or other place		27/2006	D-14	· !	Mare - land
Baltimore,	permit. Pa Departmen Important: any injury		4 ☐ Donation 5 ☐ Other (S		Meti		matory, I					
Ba	permit. Pages Department of t Important: if its any injury or of		16.50	Casecho	J		750 Belai					Home, P.A. nd 21087
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death.	Do not ent	er the mode of dying	g, such as cardia	or respiratory ari	est,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	2	Chrs	low	Sis					Onset and Death
	/Medical Examiner		resulting in death)	Due to	o (or as a consequ	nce of):		Incel				
Sp.	LAGITITIE	_	Sequentially list conditions,	b	allo	wox	100	maler				
	sit ad	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conseque	ence of):						
٧	and I-tran	кап	that initiated events resulting in death) Last	c. Due to	o (or as a conseque	ance of):						
8760,	cate be executed physician and the burial-transit			500 11	o (or as a conseque	erice di).						
87	Sal Sh	Physician/Medical		d								
9 x	The law requires that the death certific tte has been signed by the attending p age 2 should be detached for use as	/Me	IF FEMALE:	23c If yes o	utcome of pregnan	ICV.						
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	birth 2 - Fetal	death 3	Ectopic pregnancy			230	d. Date of delive Month	ny Day Year
o.	at the de by the stached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk	gnant at time of dea nown	alli 5	Other (specify)					
σ.	that t ed by detac		Part II. Other significant condition	ons contributing to	death but not resul	tina in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use	contribute to th	e cause of death?
Records,	uires sign id be	d by		·			, 3		1 □ Y			ably 4 Unknown
Ö	w requ been shoul	ete										
3ec	elaw hasi	Completed							24a. Was a autop: perfor	sy /		osy findings available npletion of cause of
		ပိ								2 No	1 Yes	2 🗆 No
Vital	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Otho		ath (Check only or	ne)		
ō	Physician: this certific ral director,	၉	1 Yes 2 No 27. Manner of Death	IL.		R/Outpatien		4 Nursing r	lome 5 Pesid)
L	ing After une	lon	1 Natura! 5 ☐ Pendin		e of Injury anth, Day Year)	28b. Time of Injury	28c. Injury Work M 1 ☐ Y		28d. Darribe h	ow injury o	occurred	
Sic	at at at	icat	Accident investig	not be				′es 2□No	004 1			(O-)- 11
Division	or Attend after death Director: /	Certification:	4 Homicide determ	ined 200. Flat buil	ce of Injury - At hon ding, etc. (Specify)	ne, iaim, sir	eet, ractory, office		28f. Location (S City or Tow	n, State)	vuringer or Hura	Houle Number,
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th		29a. Certifier Certifyin	on Physician: To the	a bost of my know	dodgo doath	occurred at the time	a data and place	and due to the			
	24 hos 24 hos Fun etely	Medicai	(Check only 2 Medical	Examinar: On the	basis of examination	on and/or in	estigation, in my op	inion, death occi	urred at the time, o	ause(s) ar ate and pl	ace, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie		inioi statoa.		29c. License	number	- 2	9d. Date s	signed (Month, L	Day, Year)
	- s - ō		DAIL OF	Jan 1/1	/ /		T 2	2264		TAM	144014	(L 2006
	الاما		30 Name and address of Sarah	who completed as	use of death flare	230) /T	Print)	()0)	(7000	7	(2000)
	12		30. Name and address of person	- (4 A A	2 death (tem)	DA A	000.	10				
2 2	Sta	ate	31. Date filed (Month, Day, Year)	32.	Registrar's Signatu	1L6	my!		140			
	Registi			6 2006		de A	CAR D					

DHMH 17 Rev 1/2001

DAVID

1 - State

		1 - State Registrar		C	ertificate of	Death		Reg. No.	00000
Physici		Decedent's Name (First, Middle, Last)		T. HC	OPER		2. Date of D Month	Day Y	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give s 600D SAMAR	TAN HOSP	PITAL	4b. City, Town, o	I MOR		4c. County of	
Funeral Director			7. Age (In)	yrs. last birthda Yrs.	y) If Under 1 Year Months Days		1rs. 8. Date of Bi (Month, D 09-26	irth 9 lay. Year) -1918	Birthplace (State or Foreign Country) MARYLAND
ryland how		Usual Residence of Decedent 10a. State 10b. County		. City, Town or					10d. Inside City Limits
he Ma	Director	MD. BALTIMO	KE		TOWS	ON	-		1 ☐ Yes 2/CXNo
3a or 2	i Dir	10e. Street and Number 21 STONEWAIN	COURT APT.	. 2-B	10f. Zip Code	1204		10g. Citizen of Wha	•
Dallilliore, INIGINITIES AND A INIGINATION PORTION PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY IS THE PROPERTY OF THE PROPERTY PROPERTY OF THE PROPERTY PRO	by Funerai		12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates:		3. Was Decedent of I If Yes, specify Cub	Hispanic Origin? an, Mexican, Po	(Specify Yes or Nuerto Rican, etc.)	o- 14. Race -	American Indian, White, etc. WHITE
72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation a completed)	(Gi	cedent's Usual Occup ve kind of work done	during most of	working	16b. Kind of Busin	ess/Industry
l Z I Z I led within lygiene. her than nt, tre Ma	Completed	Elementary/Secondary (0-12) 12 YEARS	College (1-4or 5+)	life	MANICUI	RIST			MPLOYED
should be fill and Mental Himarked out	To Be		JAMES TAYLO			IRE	NE CHAI	MBERS	
MC stranger tranger		19a. Informant's Name/Relationship (Type SHAUN A. CONNACHER	(SON)					ber, City or Town, Sta WSON,MARYL	
Dall(IMOTe, permit. Pages 1 a Department of Her mportant: If Item iny Injury or othe		20a. Method of Disposition 1 XXBurial 2 Cremation 3 R. 4 Donation 5 Other (Specify)		 b. Place of Dis cemetery, c 	position (Name of rematory or other pla IDGE CEME)	ce) 01-	Og-2006	20c. Location - Cit	
permit. Departr Departr Importu		21. Signature of Funeral Service License			22. Name and Addre		RAL HOME	1050	YORK ROAD ON,MD.21204
	-	23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	cations that caused the d						Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sept	tic	Shoc	K			Onset and Death
Examiner		Sequentially list conditions h	Due to (or at a cons	sequence of):	O Is	che	mia		
led Isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):	L .				
execu	Examin	that initiated events cresulting in death) Last	Due to (or as a cons	sequence of):	Draw		yang		
A 00 (00, 42) entiticate be executing physicien and ise as the burial-trans	Medical	C					7	l	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: Attentials certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	B Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
s that I	by Ph	Part II. Other significant conditions con	tnbuting to death but not	resulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco use contribu	te to the cause of death?
w requires to been signed should be	ted	- Asporation	on the	New	19		_ 10	Yes 200 3	Probebly 4 Unknown
he law he has b	Completed	Deep veno	no their	(100 m	<u>S</u>	_	24a. Was auto perfo	psy prior deat	
cian: T	Be Co	25. Was case referred to medical examiner?				26. Place of 0	1 ☐ Yes Death (Check only		Yes 2□ No
Physic This ce	ို	1 Yes 2 No	/	2 ER/Outpati		4 🔲 Nursin		idence 6 Other (Specify)
tending leath. for: After the funer	ation	1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year	r) Injury	Wor	rk? Yes 2 □ No	28d. Describe	how injury occurred	
Division: To the Hospital or Attending within 24 hours after death To the Funaral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, ecify)	street, factory, office		28f. Location (City or To	(Street and Number o wn, State)	r Rural Route Number,
ne Hospit n 24 hour ne Funara bletely fills	edicai (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my lier: On the basis of exam and manner stated.	knowledge, de nination and/or	ath occurred at the tir investigation, in my c	me, date and pla opinion, death or	ace, and due to the courred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
To t To t com	Σ	29b. Signature and title of contifier	MD			se number	>	29d. Date signed (M	fonth, Day, Year)
3		30. Name and address of person who cou	mpleted cause of death (I	Item 23a) (Typ	9. Print) 5 601	och R	aver Br	VD B	2 (frue MI)
Sta Registra		31. Date filed (Month, Day, Year) -	32. Registrar's Sig	gnature	1007				
DHMH 17 Rev 1/20		JAN U 6 Z	UUS JAMES	13	GOBALS"				
				ORIG	INAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 6

00050

			1 - For Stata Registrar	State of Ma		rtificate of	lealth and M Death		iene 19. No.	006	000	51
	Dhusia		1. Decedent's Name (First, Middle, La	ast)				Date of Deat Month	h Day	Year	3. Time of	Death
	Physic /Medi		Barbara C. Hag	gerty				January	2,	2006	3:01	A^{M}
1	Examir		4a. Facility Name (If not institution, gire	ve street and number)		4b. City, Town, o	or Location of Death		4c. C	ounty of Death		
100		海	10104 Gravier Co				ry Villag			tgomery		
	Funeral		20 /	Sex 7. Age 1 M 2 S F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	 Date of Birth (Month, Day, 	Year)	9. Birth Cou	place (State o intry)	r Foreign
	Director		036-20-6010 Usual Residence of Decedent		75 118.			Nov. 23	, 19.	30 Rhod	le Isla	nd
	land 1		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside Ci	ty Limits
	f she	ō	Maryland Montgom	0.837	Montgomon	17:11000					1X Yes	-
	28a	Director	10e. Street and Number	lely	Montgomer	y VIIIage	.	11	Og Citize	n of What Cou	intry?	
	with Sa or	۵										
	na 23	era	10104 Gravier Co	12. Was Decedent E	ver in U.S. 13.	20886 Was Decedent of H	dispanic Origin? (Spe			ed Stat		
(0	within 72 hours after death with the Maryland ane. than "natural", or itema 23a or 28a-f show the Modical Exerpitational be multiled at	Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No			lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		Black, White,	, etc.	
21215-0036	al', o	þ	3 \\ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2X No	Specify:		S	ресіfy: Whi	te	
9	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occup	pation		16b. Kind	of Business/Ir		
21	thu.	nple	Elementary/Secondary (0-12)	Coflege (1-4or 5+	iife.	DO NOT use retire	during most of works d)	ng				
21	ad wi	Co		2	Cong	ressional	Liaison]	Fede	ral Gov	ernmen	t
nd	d oth	Be	17. Father's Name (First, Middle, Las.	t)			18. Mother's Name	(First, Middle, A	Maiden S	umame)		
Maryland	Meni Meni arke	L _O	William Callahan				Gertrud	e Dillo	1			
a	2 sho and ie m		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	al Route Number,	City or T	Town, State, Zij	o Code)	
≥ `	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23s or 28a-f show any injury or other traumatic event, the Modical Exactional Page 1 and be notified at Once.		William C. Hagge	rty/Son	1010	4 Gravier	Court, M	ont ome:	cy V:	illage,	MD 2	0886
Baltimore,	of H of H iter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [Removal from State	20b. Place of Dispo	osition (Name of matory or other place		ate	20c. Loca	tion - City or T	own, State	
Ĕ	Pag ment ant: i		4 ☐ Donation 5 ☐ Other (Speci		St. Ann'	s Cemeter	v 2006	(Crans	ston, R	hode Isl	and
a	permit. Depertrimports any injure.		21. Signature of Funeral Service Lice	осее	2:	2. Name and Addre	ss of Facility Rob	ert A. I	Pumpl	rey Fu	neral 1	Home,
<u> </u>	89 E 29		1 Stime !	Kerry.	M00803 R	ockville,	ss of Facility Rob Inc. 300 Maryland	20850-	-2805	omery A	venue	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused to	he death. Do not en	ter the mode of dyir	ng, such as cardiac o	or respiratory arre	st,		Approximate Interval Bety	e veen
12	Physician		fmmediate Cause (Final disease or condition								Onset and D	Death
	/Medical		resulting in death)	a. Stage 4 Due to (or as a	Breast C. consequence of):	ancer					18 Year	cs
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89	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Med		3-21								
Вох	th cer endir r use	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		DEctopic pregnancy			23	d. Date of deliv	өгу	
m.	deal	icie	in the past 12 months? 1 ☐ Yes 2 🗓 No	4□Pregnant at ti		Other (specify)				Month	Day Y	'ear
P.0	at the by the tachi	Physician/Med	9 Unknown	9□ Unknown								
Ś	as tha	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use	contribute to t	he cause of d	eath?
ğ	w require been sig should b							1 X Ye	s 2 🗆	No 3 ☐ Prot	oably 4 DU	nknown
000	s bec	Completed						24a. Was ar	1 :	24b. Were auto	psy findings a	available
2	: The law cate has , page 2 s	шо						autopsy	/	prior to co death?	mpletion of ca	iuse of
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tal	iffice for, 1		25. Was case referred to medical				26 Place of Death		M No	1 🗆 Yes		
Vita	rsician: Th s certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	2 RR/Outnation	ot 3C DOA Oth	26. Place of Death	(Check only one)			
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Physic	rian	Imm	ediate Cause (Final	ry one cause on ea	ch line.	1.	34.		1-	TI	/ .			Interval Between Onset and Death	
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To tr within	ф	29b.	Signature and	title of certifier	o completed cause		M.D	,	29c. Licer	0546	182		29d. Da Jan	ate signed (Month,	Day, Year)	
	$ \psi $	30. N	lame and addr	ess of person wh	o completed cause	of death (Ite	em 23a) (Type, Pri	nt)	1		211		A. A	21215	
and the	State	31. [Patro Date filed (Mon	th, Day, Year)	32. 1	gistrar's Sign	nature -	1000	evere	- Ave		Jal Eli	norg	, mrs	×(×1)	

Registrar

JAN 0 6 2006 Assess

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 1 = For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ve. 606 ton 119 If Under 1 Year **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Quantry) -940 Days Min. 18 1 ☐ M 2 👿 F 218-18-940. Usual Residence of Decedent 9 Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natursl", or iteme 23a or 28a-f show other traumatic event, the Madical Examinations to notified at Completed by Funeral Director 1 XYes 2 □ No Maryland

10e. Street and Number more 10f. Zip Code 10g. Citizen of What Country? 2 606 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 14. Race filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary (Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed ment of Health and Mental Hygi ant: If itam 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 10 19a. Informant's Nam Relationship (Type, Print) hter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation ö 3 Removal from State Department of Important: If any injury o Mem 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign sture of Funeral Service Licensee 22. Name and Address of Eacility hter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ir heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9□ Unknown Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy perform 1□ Yes No ours after death.

Neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month Day, Year) 30. Name and address completed cause of death (Item 23a) (Type, Print) UA 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 10:00 PM Yu-Chih Jan. 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2204 Midridge Rd. Timonium Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1↓M 2□F Sept. 24 1921 Taiwan Director 215-40-7434 84 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County worle Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatith and Mental Hygiene. ant: if item 27 is marked other then "netural; or items 23a or 28e-f ehow ury or other traumatic event, the Medical Examinar must be notified at ury or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Baltimore Timonium 10g. Citizen of What Country? 10f. Zip Code USA 21093 Completed by Funeral 2204 Midridge Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Asian 3 -Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Midical Researcher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown by informant Unknown by informant 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ho-Wen Hsu/daughter 19 Meadow View Rd., Wayland, MA 01778 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Dulaney Valley Memorial Gardens Timonium, MD 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or 4 Donation 5 Other 21. Signal re of Funeral 8 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Lowell M. 10 W. Padonia Rd., Lemmon 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Asphyxia B HANGING 10minutes Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause the underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy 2 Fetal death Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 has certificate 1 Yes 2 No or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Injury by Hanging 1 Natural 5 Pending January 2, 2006 7200 P Suicide 1 ☐ Yes 2 📉 No investigation within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined St. Location (Street and Number or Rural Route Number, 2019 or Town, State) R, dae Rood LUTHERULLE, XIV 2109 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Road 3 4 Homicide Home To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18667 who completed cause of death (Item 23a) (Type, Print) fello, MD 6 Trimble H:11CT. Lutheru: 1/2, Mary land 21093 10 32. Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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OCME January 2, 200)6
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMA WBIO, MD 111 Penn Street Baltimore, Marylar	1 01001
State Registrar IAN 0 4 2006	nd 2.1.201 I

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	/Medi Examir		4a. Facility Name (If not institu	ition, give stre	eet and number	r)		4b. City, Town, o	r Location of	Death		4c. Co	unty of Deat	TIV-JU AII
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	Funeral		5. Social Security Number	6. Sex	7. A	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day,		9. Birt	hplace (State or Foreign buntry)
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Maryland	2 0 0 0		19a. Informant's Name/Relati		,	<i>-</i> .		ng Address (Street						Zip Code)
	s 1 and 2 f Health item 27 I		Patricia A. 20a. Method of Disposition	Hastir	ngs (wi	20b. Pl	lace of Dispo	4 Harford		- For	rk, Mar	yları c. Locati	d 21	L051 Town, State
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п			23a. Part1. Enter the disease shock, or heart failure.	, or complication	tions that cause cause of each	ed the death.								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		/ .	_	ome	_ /	Lu	11				Onset and Death
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Year **Physician** Month January 1, William Eugene Holt, Sr. 12:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Health Services Rossville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral XX**M 2□ F Director 77 Yrs 231–24–6723 Oct. 1, 1928 Virginia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location ir than "natural", or itame 23s or 28s-f show 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Middle River 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after deeth with 1 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itame 23a or 2 and highry or other traumatic event, the Musical Examinet must be no once. 10f. Zip Code 10g. Citizen of What Country? 3816 Chestnut Road 21220 U.S.A. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1XX lever Married 2 Married MXYes 25No If Yes, Give Year or Dates: Korea Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Forklift Operator Boat Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Rosco Holt Virginia Dare Fultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, William Holt, Jr. (Son) 422 Potomac Street, Baltimore, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XDCremation 3 ☐ Removal from State Bayview Crematory, Inc. Jan. 2, 2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** HYPOXIA /Medical Due to (or as a consequence of): Examiner MYOCAPDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CEREBRO VASCULIAR 3 Probably 1 ☐ Yes 2 ☐ No 4 DUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 1 ☐ Yes 2.2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3 DOA After the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural 5 Pending investigation death. 1 TYes 2 □No Director: / 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO. PHILODELIMA 9106 DENNS . H. ODIE 32. Registrar's Signature 31. Date liled (Month, Day, Year) JAN 0 3 2006 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Né. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 **Physician** 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4d. County of Death Examiner Anot 4b. Town, or Location of Death DALTMOR MORE If Under 24 Hrs. 8. Date of Birth (Month, Day 5. Social Security Number last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F Min. Director Yrs. Hunter Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and tem 27 Is marked othar than "neturel", or items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked othar than "neturel", or itams 23a or 28a-f show other traumetic event, the Madical Examinar must be multified at NID 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 SF 12. Was Decedent Armed Forces Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 2 No Specify: 3 Widowed 4 □ Divorced 71te 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1,4or 5+) 17. Father's Name (First, Middle, Last) To Be 18. Mother's Name (First, Middle, Maiden Sumame) Sorenser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City r Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ŏ Department of Important: If eny injury or once. * 4 □ Donation 5 □ Other (Specify) Evans Funeral 3 106 Forest Hill 21. Signature of Funeral Service License 22. Name and Address of Facility -vans chapel of no. Parkville mD 21234 23a. Part 1. Enter the disease, or complications that cause he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each (in). Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LYDCARDIA hr. /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 9 Unknown certificate has bean signad by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 90 3 Probably 4 Unknown the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 x Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Natural 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) 44604 06 30. Name and addres person who completed cause of death (Item 23a) (Type, Print) Packville MICHAEL P018 HARFORDRE MO 2123-

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JAN 0

3

32. Registrar's Signature

WESTON D. INSLEY 06-0052 in Black Indelible Ink. Ensure All Copies Are Legible. Please Type or Print i Unpend item#23a,27,28a_f,penyE,685 RKD State of Maryland / Department of Health and Mental Hygiene Amend item#23a, perME, G851, 1/25/06 TT

Certificate of Death

Beg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year Insley Weston Derek JANUARY 2006 3:18P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4510 KENWOOD AVE BALTIMORE **OVERLEA** Months Days Hours Min. 8. Date of Birth Month Days Hours Min. August 22, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** t**∑**M 2□F Months 218-23-6596 22 Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD Baltimore Overlea Director 1 Yes 2/0/No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4510 Kenwood Avenue 21206 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No 1 ☐ 1 — 1 ☐ 5
If Yes, Give
Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Manufacturing permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any lighty or other traumatic event 908.8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Insley Robert Carolyn Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn A. Insley-mother 931 Fairmount Ave., Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp 1/7/06 4 Donation 5 Other (Specify) Towson, MD 21. Signature of Funeral Service Densee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Bronchopneumonia Complicating Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Methadone and Butalbital Intoxication and Cocaine use /Medical Due to (or as a consequence of): Examiner saquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, 中 Due to (or as a consequence of): ettending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy performed? 2 No Director: After this certification in by the funeral director, 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 Other: 4 Nursing Home 5 Residence 6 Hother (Specify) SCENE 28a. Date of Injury 28b. Time of Injury 1.0 Injury Certification: 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred unk 1 Natural 5 Pending death. investigation 3:30 P 1 Yes 2 No 2 Accident Jan. 2, 2006 6 X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State 1510 Kenwood Ave completely filled in by 4 - Homicide House within 24 hours a To the Funeral I Overlea, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. JANUARY 3, 2006 30. Name and address of person who completed and death (Item 23a) (Type, Print) RNB 10 MO 111 PENN STREET BALTIMORE MARYLAND 21201 ANA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State of Marylar Registrar		artment of H			ene	6 00061
P+	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	3. Time of Death
	/Medic Examir		David Doyle Jenkins 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	January	3, 20 4c. County of	
	<u> 5</u>	Ą.	Gilchrist Center		Tows			Ва	ltimore
. 4	Funeral Director		5. Social Security Number 256-52-9228 Cusual Residence of Decedent	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 5,		9. Birthplace (State or Foreign Country) Georgia
	he Maryland 8a-f show pullied at	Director	10a. State 10b. County 10c. Ci Maryland Baltimore	ity, Town or Lo	Bal	Ctimore			10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	and the name of th		10e. Street and Number 4016 Silvage Road		10f. Zip Code	236	10	g. Citizen of W U.S	•
36	irs after death I', or itema 2	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Uarmed Forces? 1 Was Decedent Ever in Uarmed Forces? 1 Was Decedent Ever in Uarmed Forces? 1 Was Decedent Ever in Uarmed Forces? 1 Was Decedent Ever in Uarmed Forces? 1 Was Decedent Ever in Uarmed Forces? 1 Was Decedent Ever in Uarmed Forces? 1 Was Decedent Ever in Uarmed Forces? 1 Was Decedent Ever in Uarmed Forces?	9-	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race	American Indian, K, White, etc.
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	Completed by Funeral	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) 5+	16a. Deced (Give life. L	dent's Usual Occupa kind of work done o DO NOT use retired, tems Anal	luring most of work)	king	Bb. Kind of Bus	of Defense
/land 2	2 should be filed within and Mental Hygiene. Is marked other than "raumatic event, the Men	To Be Co	17. Father's Name (First, Middle, Last) David Chrystol Jenkins	Ogs	reals mu	18. Mother's Nam	orene Ho	aiden Sumame	
e, Mar)	1 and 2 sho Health and N em 27 Is me ther traums		19a. Informant's Name/Relationship (Type, Print) Anita Lynn Bearden (daughter) 20a. Method of Disposition	1662	ng Address (Street a	d., Spar	ks, MD 2	1152	
mor	Pages nent of H int: If Its		Contract of the contraction of the contract of		isition (Name of matory or other place Crematory	1			City or Town, State
Balti	permit. Pages Department of Important: If It any injury or once		21. Signature of Funeral Service Licensee	22	2. Name and Addres 705 Belai	s of Facility SC	himuneb 1	Funoral	Hamas
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consec	th. Do not enti	er the mode of dying	g, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Undertying	S [uence of).					0475
60,	ate be executed hysicien and the burial-transit	al Exam	Cause (Disease or righty that initiated events resulting in death) Last Due to (or as a consequence)	luence of):					Dry's
13/0 / 45 P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy. completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. tf yes, outcome of pregnat 1 Live birth 2 Feta 4 Pregnant at time of d	al death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h Day Year
1/3 ords, F	equires tha en signed l ould be det		Part II. Other significant conditions contributing to death but not res	ulting in the un	nderlying cause give	n in Part I.			oute to the cause of death?
Dava 1/	Physician: The law requires this certificate has been sign ral director, page 2 should be	e Completed	25. Was case referred to medical					d? de	ere autopsy findings available or to completion of cause of ath? Yes 2 \(\text{No} \)
Jeneums	ittanding Physicie death. ctor: After this cert r the funeral direct	ToB	examiner? 1	ER/Outpatient 28b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursing Ho	me 5 Residence 28d. Describe how		(Specify) No spice
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At h building, etc. (Specification)	(y)			City or Town, S	State)	or Rural Route Number,
	e Hospital 124 hours a Euneral i letely filled	edicai	29a. Certifier (Check only one) (Check only one) (Check only one)	wledge, death ition and/or inv	occurred at the time restigation, in my op-	e, date and place, inion, death occurr	and due to the caused at the time, date	se(s) and mani and place, an	ner as stated. d due to the cause(s)
	To the within 2 To the complet		29b. Signature and title of certifier		29c. License	number P303	290	Date signed	Month, Day, Year)
	1541		30. Name and address of person who completed cause of death (Item Annual Charles)	n 23a) (Typg. F	D 50 Print) les St	Brown	memo	21204	
100	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 6 2006 32. Bigistrar's Signa		edi				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#2a,2/,28a f,pen#1,652,2/2/00 in. State of Maryland / Department of Health and Mental Hygiene. DAMIEN GREY JANKOWSKI 06-00008 RJCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 1, Jankowski January 2006 3:47 a.™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview N/A Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 8 1X M 2 ☐ F Yrs. Director 218-73-8488 October 24,2005 | Baltimore, Maryland Usual Residence of Decedent Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehov other traumatic event, the Medical Examiner must be notified at Director MD. Baltimore Dundalk 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1905 Wareham Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2X No White ۵ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within Hygiene. ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) N/A N/AN/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental h Sean P. Jankowski Shannon M. Barton ျှ Department of Health and 2 shi Important: If Item 27 ie ma any injury or other traumat 2005. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Parents Sean Jankowski/Shannon Barton 1905 Wareham Road, Dundalk, MD. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 4, 1 ♥ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dundalk, Md. Oak Lawn Cemetery 2006 21. Signature of Funeral Service Licenser Conneity Funeral Home Of Dundalk, P.A. thone 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the dishas , or complications that cause the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail in . List only one cause on each lin Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sudden Unexplained Death in Infancy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in insulate cause. Enter Underlying Cause (Disease or injury Directo for as a noneuguence off Examine The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e o 9 Unknown 9 Unknown ۵ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of d 1 h?
1 ∆ Yes 2 □ No 24a. Was an has page 2 autopsy performed? certificete 1 X Yes 2 No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို ™Yes 2 No spital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other:

28a. Date of Injury Fnd (Month, Day Year)

28b. Time of Fnd | 28c. Injury at Injury this After thi 27. Manner of Death Certification: 28d. Describe how injury occurred Hospital or Attending ospital C.
4 hours after dea.
7-ral Director: After 1 Natural 5 Pending 2:59 1/1/06 1 Yes 2 No investigation A 2 Accident in 24 hours.
the Funeral Director of the Funeral Direc 6 X Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Bural Route Number, City or Town, State) 3020 Pun leer Rd. determined 4 \ Homicide Found in residence Dundalk, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME JANUARY 2, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar JAN 0 6 2006

			State of Maryle				-	_	
			1 State	•	rtificate of I			2006	00063
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia		PAULA MARIE JONE	= 5			JAN 4	Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4c. County of Dea				
			Genesis Multi-Medical Center	wson		Balti			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In)	yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Pay, Oct 4,	1951 Ma	thplace (State or Foreign ounter) ryland
	pu 🗼		Usual Residence of Decedent 10a. State 10b. County 10c.	. City, Town or Lo	ocation				10d. Inside City Limits
	Aarylis f aho	ŏ	Maryland N/A	Ra1	ltimore				1 ☐ Yes 2 ☐ No
	the 128a-	by Funeral Director	10e. Street and Number	Dai	10f. Zip Code		10	g. Citizen of What C	ountry?
	3a or		419 Scarsdale Road		2122	4	ı	USA	
	deatl	ner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp. n. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
õ	or lite	y Fu	1 Never Married 2 Married 1 Yes 2 XNo		1 ☐ Yes 2 ☒ No	Specify:			hite
3	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural", or Items 23a or 28a-f ahow event, Tra Madical Exertified Tratal be natified at	d be	3 ☐ Widowed 4 ☒ Divorced Year or Dates: 15. Decedent's Education	16a Decer	dent's Usual Occup	ation	1 1	6b. Kind of Business	s/Industry
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77	filed withi Hygiene. other than	шо	Elementary/Secondary (0·12) College (1·4or 5+)	Sc	cheduling			Medic	al
ğ	0 8 0 8	Bec	17. Father's Name (First, Middle, Last)				e (First, Middle, M		-
Maryland	should be ind Mental a marked o umatic eve	To	Edward Wesley Jones					ella Hade	
Jar	2 short and lam		19a. Informant's Name/Relationship (Type, Print)					City or Town, State,	Zip Code)
	1 and Health Sm 27 Sm 27 Sher t		Patricia Korman, Daughter 20a. Method of Disposition 20		5 Mast B1 osition (Name of			Oc. Location - City o	r Town, State
פֿר	ages nt of h				osition (Name of matory or other plac ematory I				, Maryland
Baltimore,	nit. Pa artmel ortant injury		. 4 □ Donation . 5 □ Other (Specify) 21. Signature of Funeral Service Licensee						, naryrand
m	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 Is marked any injury or other traumatic e <u>pnce.</u>		Thomas Gregor		2 Name and Addre Cremation 299 Frede	Society rick Koad	of Maryl 1 Baltimo	and Inc. re, Maryl	and 21228
	PART I		23a. Part1. Enter the disease, or complications that caused the of shock, or heart failure. List only one cause on each line.	death. Do not ent	ter the mode of dyir	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
- 1/4	Physician								Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Let Ge Due to (or as a condition sequentially list conditions.	nsequence of):	7,000	1 11 1 1 1 1			91.
	Examiner	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cor	e fai	elene			moneto	
	ed Isit	nine	if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	isoquerica orj.					
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P.0	that the	Phy	Part II. Other significant conditions contributing to death but no	t resulting in the u	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds,	uires tha signed Id be del	d by					1 🗆 Ye	s 2 No 3 F	Probably 4 Thinknown
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g	Physician: The I this certificate ha al director, page	Be C	25. Was case referred to medical				th (Check only one)	
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Division of Vital Records,	Attending Physician: or death, ector: After this certifice by the funeral director.		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	Wo	yat k? Yes 2 ∐No	28d. Describe ho	w injury occurred	
<u>s</u>	ttend death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury	At home, farm, st		192 5 1140	28f. Location (Str	eet and Number or F	Rural Route Number,
<u>≥</u>	- a - c	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - building, etc. (S)	pecify)	,,		City or Town	, State)	
_	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier Certifying Physician: To the best of my						
	n 24 h n 24 h he Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or in	nvestigation, in my	opinion, death occu	rred at the time, da	ite and place, and di	e to the cause(s)
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Σ	29b. Signature and title of certifier		29c. Licens	se number	29	d. Date signed (Moi	nth, Day, Year)
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	10		30. Name and address of person who completed cause of death	(Item 23a) (Type,	, Print)	1000	ROAM	UNTELL	P. A 21045
	, 	ate	29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death Shawnyara Cupra 31. Date filed (Month, Day, Year) JAN 0 6 2006	Signature -	P- W	, ,, ,,		LU CUIT	131/17
	Regist		JAN 0 6 2006 Acres	15 PM	JOHN J				
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John Allen Johnes 1/3/06 outo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death January 3, Physician John Allen Jones 2006 1:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner Gilchrist Center Towson Baltimore Jan. 10, 1914 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1XM 2□F Months Hours 91 214-07-9214 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, it a Medical Examinar must be notified at 1 ☐ Yes 2 X No Directo MD Carroll Eldersburg 10e. Street and Number Of. Zip Code 10g. Citizen of What Country? 1017 Courtland Drive 21784 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give X
Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 is marked other than "ns Elementary/Secondary (0-12) College (1-4or 5+) 12 Delivery manager Philips Oil Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Claudia Mills Ralph McGee Jones, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 ts rr any injury or other traum <u>once</u>. 1017 Courtland Drive Eldersburg, MD June Carroll Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jan 5, 1 中Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Memorial Pk Cambridge, MD 4 Docation 5 Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, MD 21. Signature of Funeral Service Licensee am au Approximate Interval Between Onset and Death 23a Part1. Inter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Im ediate Cause (Final di ease of condition res mindeath) Pnysician COVOMAN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury Due to for as a consaduence of use as the burial-transit requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No 2K No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Satural 5 Pending eftar death. 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours eftar To the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JAN 0 4 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

122

N. Charles St.

		•	State of Maryland / Department of Health and Mental Hygiere 0 0 6 5 Certificate of Death
	WON B		Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physici		Eveline King Month & 2006 6:55"M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
			UNIVERSITY OF MARYLAND BALTIMORE NIA
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Director		227-72-9656 1 M 246F 5 5 Yrs. 01-4-1951 Usual Residence of Decedent
	riand ow		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Man B-f eh	tor	MD BALTIMORE 1 Pres 2 No
	or 28	Jire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	ath wi	rai	2113 CLIFTON AVE. 21217 U.S.A.
	er de	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	irs aft	by Funeral Director	1 Never Married 2 Married 1 Sec. 1 Specify: 1 Yes 2 No Specify: Sp
215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f ehow then "natural", or items 23a or 28a-f ehow he Mariland and the motilised at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind of Business/Industry
21	ithin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+)
7	filed w Hygier other th		12. Father's Name (First, Middle, Last) College (1-407 5+) House FE Dome STic 18. Mother's Name (First, Middle, Maiden Surname)
anc	ntal Hed of	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Maryland	S should be filed with and Mental Hygiene. Is marked other ther aumatic event, The In	P_	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
S			THERMAN KING HUSBAND 2113 CLIFTON AVE BAHO.MD. 21217
Je,	s 1 and of Health Item 27 other tr		20a. Method of Disposition Date 20c. Location - City or Town, State
altimore,	Pages ment of ant: If Its ury or o		1 Burial 2 Oremation 3 Removal from State 4 Donation 5 Other (Specify) METHO Cent. 1-7-06 BA 140 MD
Balt	permit. Pages Department of Important: If II eny Injury or c		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Michael Zichier Fun Sic
	40 = 0	0	Weller Station 3512 Frederick AVE BAITO, MU21229
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final
读	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Any strophic Lateral Science Sist 2 yrst
	Examiner		Due to (or as a consequence or):
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Einer Underfying Cause (Disease or injury
V	ecuted and trans	Examiner	that initiated events C.
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687	ficate physis the	edicai	d
Вох	that the death certifi ed by the attending I detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
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ta	ificete or, pa	a	1 Yes 2 No 1 Yes 2 No 25. Was case referred 9dical 26. Place of Death (Check only one)
Ž	Physician: r this certifice ral director, I	To B	examiner? 1 Yes 2 No
0	ng Ph fter th meral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 1 ☑Natural 5 ☐ Pending 1 ☑Natural 5 ☐ Pending 1 ☑Natural 5 ☐ Pending 1 ②Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28b. Time of 28c. Injury at Work?
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ر	To the Hospital or Attending Physician: The I within 24 hours eiter death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	within to the comp	Ň	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
)			1 2 Tot NB D46426 1/5/56
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAI Pater 22 5. Green 3+ Baltin 32 AND 212 32
124	Sta	to	Neil tota 22). Greene It Beltinere MD 21201 31. Date filed (Month, Day, Year) 32. Begistrar's Signature
K.	Registr		JAN 0 6 2006
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Amend Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Kocher Eloise B. Januaru 2006 9:15 PMM 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4 Linwen Way Baltimore. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. June 21, 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 200 F 83 233-48-2275 Yrs. 1922 West Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blud., Apt. 1512 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Emma Mae Baxter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carol Knapp (daughter) 4 Linwen Way, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State New Martinsville, 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State North View Cemetery 1/7/2006 * 4 ☐ Donation 5 ☐ Other (Specify) West Virginia 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of):

/Medical

Physician

/Medical

Examiner

Funeral

Director

ral', or Itema 23a or 28a-f show Examiner must be notified at

Be Completed by Funeral Director

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with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " working yor other traumatic event."

Prysician Examiner

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Hospital or Attending Physician: The law requires that the death certificate be executed

death.

within 24 hours efter deat To the Funeral Director:

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Medical

State

Registrar

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medicai ģ Be Completed

Certification: To

Immediate Cause (Final disease or condition resulting in death) that initiated events IF FEMALE: 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to finedical examiner?

Sequentially list conditions, if any saling the cause. Enter Underlying Cause (Disease or injury resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 DW6

4 Homicide

(Check only onel

29a. Certifier

9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 2 Fetal death 4□Pregnant at time of death

Due to (or as a consequence of)

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day Month

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

autopsy performed? 20 26. Place of Death (Check only 6 Doughter's Residence 28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Hospital: Other: 4 Nursing Home 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner eath 28b. Time of 28c. Injury at Work? 1 UNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cert

29c. License number

🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

e on who completed cause of death (Item 23a) (Type, Print) 30. Name and 1d 1505 Osler

31. Date filed (Month, Day, Year) JAN 0 6 2006

32. Registrar's Signature

			4	For State Registrar		State	of Mary		artmer e <i>rtifica</i> i		ealth and Death	Mental Hy	/giene Reg. No.	000	000	67
		ā.	24	Decedent's Name	(First, Middle, La	st)						2. Date of D Month			3. Time	of Death
		Physicia /Medic	_	William				Knight				Janua			12:0	5 A M
		Examin		4a. Facility Name (//		e street and n	umber)		-	, Town, or unda:	Location of Dea	th		County of Dea		
	vi.	Funeral		5. Social Security N	umber 6. S		7. Age (In	yrs. last birthday		r 1 Year Days	If Under 24 Hrs	8. Date of B	irth	9. Bi	rthplace (State	or Foreign
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		and w		Usual Residence of 10a. State	10b. County		100	c. City, Town or I	ocation						10d. Inside (City Limits
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4	36	or He	by Fu		ed 2 Married	1 Tyes	2 XNo Sive		1 🗆 Yes		Specify:			Specify: W		
Knight	5-0036	hours tural		3 Widowed	15. Decedent's E	Year or	Dates:	16a, Dec	edent's Usu	ual Occup	ation		16b. Ki	ind of Busines	s/Industry	
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5		1 and Healt tem 2 other		20a. Method of Dis				0b. Place of Dis	position (Na	me of	1	Date		ocation - City o	r Town, State	
0	Ē	ages ent of nt: if if			TCremation 3 ☐ 5 ☐ Other (Speci		m State	cemetery, ci Bayview				ary 10, 006	Balt	imore	City. N	1D.
Villiam	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23s or 28s-1 ehow eny injury or other treumatic event, the Marical Examiner must be purified at once.		21. Signature of Fu			10		22. Name a	nd Addres	ss of Facility Funeral					
$\stackrel{\cdot}{\supset}$	ä	9 G E . 9		Cont	hours 1	one	elly		7110	Soll	ers Poir	nt Road,	Dung	alk, MD	. 21222	2
				23a. Part1. Enter t shock, or hea	he disease, or con int failure List only	plications that one cause on	cause Libe each line.	death. Do not e	nter the mo	de of dyin	g, such as cardia	ic or respiratory	arrest,		Approxima Interval Be Onset and	etween
4		Physician		Immediate Cause disease or condition		_ a		Chat	relati	< /r	Properte	care	2/~		14 years	
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	rds	quires m sign										1 🗆	Yes 2	⊇ No 3□F	Probably 4]Unknown
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	Ä	The I	Zom									per	formed?	death? 1 □ Ye	s 2 No	54430 01
	/ita	cian: ertific ector,	Be	25. Was case references	rred to medical	11. 11.1				100		eath (Check only				
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ŝ	á	tel or s afte al Dire	Certification:	4 🗌 Homicide		bui	lding, etc. (S	рөспу)				City of 1	own, State	7)		
		To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one)	Certifying P	miner: On the		mination and/or								n(S)
		ro the vithin To the comple	Me	29b. Signature and	title of certifier	and the	0	0	25	9c. Licens	e number		29d. Da	te signed (Moi	nth, Day, Year)	
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		O,		30. Name and add		completed ca	use of deal	(Item 23a) (Typ	o Print)			Λ.	-/-/	1		
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	-2	Sta Regist		31. Date filed (Mor	nth, Day, Year)		. Registrar's	Signature	anti)		r					

	an	C III	24b Per Ph					2. Date of De. Month	Day		3. Time of 220	_
	cal	Gene Knapp 4a. Facility Name (If not institution, give	street and number)		4b. City	. Town, or Loc	ation of Death	<u> </u>	02	2006 County of Death	770	- 1
amin	er	University of Marylan		Center		altimor			10.	N/A		
eral tor		5. Social Security Number 6. Se 215-52-0740		(In yrs. last birt	Months		Under 24 Hrs. ours Min.	8. Date of Bird (Month, Da November	v. Year)	9. Birthp	lace (State o	r Foreigi
		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	0d. Inside Cit	y Limits
	ctor	Md Baltimor	:e	Perr	y Hall						1 ☐ Yes	2 X) No
	Director	10e. Street and Number	7			p Code			10g. Cit	zen of What Cour	itry?	
	Funeral	4114 Lockcarrow Ro	Dad 12. Was Decedent E	ver in U.S.		21236	nic Origin? (Si	pecify Yes or No	-	USA 14. Race - Americ	an Indian.	
	þ	1 Never Married XX Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	0	If Yes, spe		lexican, Puèrti pecify:	pecify Yes or No p Rican, etc.)		Black, White, Specify: Whi	etc.	
	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)			Decedent's Usu (Give kind of wo life. DO NOT L	af Occupation ork done durin use retired)	n g most of wor	king	16b. Ki	nd of Business/Inc	dustry	
		12 years 17. Father's Name (First, Middle, Last)			Glazer	10	Mothoda New	ne (First, Middle,		ss Compai	ny	
	To Be	Eugene Turner Knap	מנ					largaret		,		
	F	19a. Informant's Name/Relationship (T) Peggy J. Knapp				s (Street and I	Number or Ru	ral Route Numbe	r, City o	r Town, State, Zip MD. 212		
	1	20a. Method of Disposition		20b. Place of	Disposition (Na	me of other place)	Janu	Date arv	20c. Lo	cation - City or To	wn, State	
		TyD Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			wn Ceme		7, 2	_	Dund	alk, MD.		
one.		21. Signature of Funeral Service Licens	Conne	lly	Conne.	Address of Lly Fur Sollers	racility neral H s Point	ome Of I	Dund Dund	alk,P.A. alk,MD.	21222	
	edicai Examiner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a Due to (or as a c.		of):						Onset and D	eath
l	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	3 ⊟Ectopic p 5 □ Other (s _i				2	23d. Date of delive Month		'ear
	-	Part II. Other significant conditions con	ntributing to death bu	t not resulting in	the underlying o	ause given in	Part I.	23e. Did to		se contribute to th	e cause of de ably 4 ∐U	
	þ							24a. Was autop	sy med?	death?	osy findings a aptetion of ca 2 No	variable use of
	Completed by							10% Yes		TAC YOS		
	Be Completed by	25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospitaf: 1 X Inpatien	nt 2□ER/Out	patient 3 D	Othor		10% Yes	ne/		1	
	To Be Completed by	examiner?	Hospitaf: 1 Inpatien 28a. Date of Injury (Month, Day	/ 28b. T	patient 3 Do	Othor	☐ Nursing Ho	10% Yes	ne) lence (i □Other (Specify)	
	To Be Completed by	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury	Year) 28b. T	ime of jury M	OA Other: 4 28c. Injury at Work? 1 — Yes	☐ Nursing Ho	1 1 Yes th Check on volume 5 Resid	ne) lence (injur	□ Other (Specify) occurred d Number or Rural) <i>0f</i> ,
	Certification; To Be Completed by	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physical Certifier 2 No	28a. Date of Injury (Month, Day	Year) 28b. T In In In In In In In In In In In In In	m, street, factor	Other: 4 28c. Injury at Work? 1 Yes y, office	Nursing Ho	10% Yes th Check only or ome 5 Resid 28d. Describe h 28f. Location (S City or Tow	lence to sow injury	G Other (Specify occurred	Route Numb	νθ <i>Γ</i> ,
	To Be Completed by	examiner? 1	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. sician: To the best of ner: On the basis of	Year) 28b. T In In In In In In In In In In In In In	me of jury M m, street, factor death occurred	Other: 4 28c. Injury at Work? 1 Yes y, office	Nursing Ho	10 Yes th Check only or ome 5 Resid 28d. Describe h 28f. Location (S City or Tow	lence (s) itreet ann, State, date and	G Other (Specify occurred	Route Numb Med. the cause(s) Day, Year)	<i>γ</i> Θ <i>r</i> ,

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3 Day **Physician** January 2006 Zenobia Martin Kendig 3:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1014 Chestnut Ridge Drive Timonium If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Pay, June 14, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year)908 Months 1 ☐ M 2 ☐ F June 216-32-5183 97 Minnesota Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Timonium 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21093 USA 1014 Chestnut Ridge Drive itema 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ No þ Specify: 3 ₩ Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 5+ permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item 2006. Teacher Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hubert George Rockwood Edith Deutschman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy M. Brennand daughter 271 Vermillion Drive; Little River, SC 29566 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 DBurial 2 Cremation 3 Removal from State Druid Ridge Cemetery 4 □Donation 5 □ Other (Specify) 1/7/06 Pikesville, MD 21. Signature of Fune al Service L 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, of compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 20 Woma /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the ettending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Dav Year 5 Other (specify) this certificete has been signed by the erral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai She sh 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D Maffezzo'lli, M.D. 515 Fairmont Ave. Towson, Maryland 21204 Richard Matrez 31. Date filed (Month, Day, Year) State JAN 0 6 2006 Registrar

			1 = For State Registrar	State o	of Marylan			of Health of Death		lental Hy	/giene	06	00070	
27			1. Decedent's Name (First, Middle, Last)							2. Date of D			3. Time of Death	_
	Physicia Medic		Violette S. Kas	st1						Januar	y 3, 20	Year 006	7:45A M	
	Examin	40	4a. Facility Name (If not institution, give	street and nu	mber)		4b. City, To	wn, or Location	of Death			ity of Death		_
		-33	Byron House				Potom	ac			Mont	gomer	v	
	Funeral		Social Security Number 6. Security Number		7. Age (In yrs.	last birthday)	If Under 1	ear If Under	r 24 Hrs. Min.	8. Date of Bi	-44-	0.00	-	
	Director		322-48-2917]M 2∭T F	85	Yrs.	Months	ays Hours	MIII.	June 2	24, 192	0 Lit	huania	
	p _		Usual Residence of Decedent											
	aryla	-	10a. State 10b. County		100. 01	y, Town or Lo	cation						10d. Inside City Limits	
	99-1	cto	Maryland Montgomer	У	Pot	comac							1 ☐ Yes 2X No	
	or 2	Director	10e. Street and Number				10f. Zip Co	de			10g. Citizen o	of What Cou	ntry?	
	ath w		4210 Kentsdale Dri				2085	4			United	State	es	
	or de	Funerai		Armed Fo		.S. 13. V	Vas Deceden Yes, specify	t of Hispanic Or Cuban, Mexica	rigin? (Spo an, Puerto	ecify Yes or N Rican, etc.)	o- 14. A	ace - Ameri lack, White		
36	s afte	by F	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes If Yes, Gi	ve		☐Yes 2X	No Specify	<i>'</i> :		Spe	cify:		
8	filed within 72 hours after deeth with the Maryland Hygeles other than "natural", or lleme 23a or 28e-f ehow ent, the Madical Extraction and be mailled at	D D		Year or D	ates:	1 40- D						Wh:	ite	_
Γ̈́	n 72	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		(Give	ent's Usual C kind of work o OO NOT use i	lone du <i>ri</i> na mo	st of work	in <i>g</i>	16b. Kind of	Business/Ir	ndustry	
2	withi ene. than	mc	Elementary/Secondary (0-12)	College (1-4or 5+)		maker	oinou)			0wn	Uomo		
ე ე	filed Hygi ther		17. Father's Name (First, Middle, Last)			Home	maker	18. Moth	er's Name	First, Middle	, Maiden Sum			_
an	d be antal	o Be	Charles Putris											
Maryland 21215-0036	shout od Me mari mati	၉	19a. Informant's Name/Relationship (Ty	pe. Print)		19h Mailin	n Address (S			Kilgus	er, City or Tox	m State 7i	o Code)	
∑	d 2 sith ar lith ar treu		Joseph W. Kastl/Sc											
á,	1 an Heal tem 2		20a. Method of Disposition	11	20b. F	lace of Dispos	sition (Name	of		enesda,	Mary1		20817 own, State	-
altimore,	nt of nt of nt of t: if it		1 Burial 2 Cremation 3 F		State Sa	rasota Park	Memor:	(place)	Janua	ry 9,				
量	ntme intent	. 4	4 Donation 5 Nother (Specify) 21. Signature - Learn Service License		ent	Park	Nome and	ddross of Cool	2006	ort A	Saraso	ta, F	lorida	_
Ba Ba	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Merital Hygiene. In the medical timportent: If it item 21 is marked other than "natural", or items 23a or 28s-1 show eny injury or other treumatic avent, the Madical Exaciling and be mailthat at once.		Jan E		4. MOO	803 Be	thesda thesda	-Chevy Mary	Chas Land	e, Inc 20814	-3501 -3501	Wisco	neral Home/ nsin Avenue	3
	线		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that one cause on e	caused the deat	h. Do not ente	er the mode o	f dying, such as	s cardiac o	or respiratory	arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Is	chemic	Cardio	mvopat	hv					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence of): Congestive Heart Failure Due to (or as a consequence of):										
	Examiner		Sequentially list conditions.											
	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):								
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9	eath certific attending p	Med	IF FEMALE:								I	***		
Вох	ath co	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live t	tcome of pregna pirth 2 Peta	Ideath 3	Ectopic pregr	nancy				Date of deliv Month		
0	the a	/sic	1 Yes 2 No	4☐Pregr 9☐Unkn	nant at time of d	eath 5□	Other (speci	⁵ y)				JOHU	Day Year	
<u>Р</u> О	that the de led by the a detached f	Phy			lands but and					20 5:1				-
s,	o o	þ	Part II. Other significant conditions con	imbuling to d	leath but not res	uiting in the ur	iderlying caus	e given in Part	1.		v		he cause of death?	
5	w requir been s should	ted								1	Yes 2₽No	3 L Pro	bably 4 □Unknown	
Vital Records,	e taw has b	Completed								24a. Was		. Were auto	opsy findings available impletion of cause of	
Œ		Sol								perf	órmed? 2⊠No	death?	2□ No	j
/ita	Attending Physicien: Thir death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?							(Check only			**************************************	
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Ē	ding F	OU:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe	how injury occ	urred	8	
Division of	tend eath or: /	cati	2 Accident investigation 3 Suicide 6 Could not be				М	1 Yes 2]No					
Ξ	after deatl	Certification:	4 Homicide determined	28e. Place build	e of Injury · At he ing, etc. <i>(Specif</i>	ome, farm, stre y)	et, factory, o	fice		28f. Location City or To	(Street and Nui wn, State)	nber or Run	al Route Number,	
	urs a urs a brei L		38	1										
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	ner: On the b	asis of examina	wledge, death ition and/or inv	occurred at t estigation, in	he time, date a my opinion, de	nd place, ath occurr	and due to the ed at the time.	cause(s) and date and place	manner as s	stated. o the cause(s)	
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and man	iner stated.			cense number						_
	7 × 10 0		250. Signature and title of certifier	Dani	رمب	7 14) 290. L	oense number			29d. Date sign	iea (Month,	vay, rear)	
f	/		Vysano	7				7660			1/	/		
	n		30. Name and address of person who co	mpleted cau	se of death (Item	n 23a) (Type, I	Print)				,			
			4 4 6 11	_ /	1 1 0									
	Sta		Alpana Goswami, M. 31. Date filed (Month, Day, Year)		119 Roc		Pike,	#G100,	Rock	ville,	Maryla	ind 2	0852-3100	4

	•	For State Registrar		State	of Maryla		artment of ertificate o	Health and f Death	Mental Hy	giene Reg. No.	006	00071
Physicia	an	1. Decedent's Name (First	t, Middle, Las	t)					2. Date of De Month	Dall Dall	n Year	3. Time of Death
/Medic	al	MOUNES	KAKI		umbas)		4h City Tour	or Longting of Dan	JANUARY	05	County of Dea	1.3017
Examin	er	4a. Facility Name (If not in NORTHWEST	-			4b. City, Town, or Location of Deat			ın	i	ALT I MOI	
Funeral		5. Social Security Number	6. Se	x		rrs. last birthday) If Under 1 Ye	8. Date of Bi	rth	thplace (State or Foreign		
Director		220-69-63	23	□M 27 F	9)4 Yrs.	Months Day	/s Hours Min	MAR. 2	ľ, 191	1	I RAN
and *		Usual Residence of Decer 10a. State 10b.	dent County		10c.	City, Town or I	ocation					10d. Inside City Limits
Manyli feho	JO.	MD	N/A			RΔI	TIMORE					1 V Yes 2 □ No
1 the 1	Director	10e. Street and Number	ПУЛ			DAL	10f. Zip Code	9		10g. Citiz	zen of What Co	ountry?
th with	ai D	6807 PARK	HEIGH	TS AVE	NUE #4	-K		21215				IRAN
r deal	Funeral	11. Marital Status		12. Was De Armed F	cedent Ever in orces?	n U.S. 13	. Was Decedent of	of Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No to Rican, etc.)	0- 1	4. Race - Ame Black, Whit	
s afte	by Fu	1 ☐ Never Married 2 3 💢 Widowed 4 ☐ D	_	If Yes, G	2 🐧 No live		1 ☐ Yes 2 💢 N	lo <i>Specity</i> :			Specify:	WHITE
Idl yidlid ZIZIOOOOO 2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland la marked other than "natural", or frems 23a or 28a-f ehow aumatic event, the Madical Examiner must be notified at			ecedent's Ed	Year or ucation	Dates.	16a. Dec	edent's Usual Occ	cupation		16b. Kir	nd of Business	
Pin 72	Completed	(Specify onl		de completed College	(1-4or 5+)	life.	DO NOT use ret	ne during most of wo ired)	orking			
od wit	Соп	0				MOH	EMAKER			_	HOME	
be fill H od oth	Be	17. Father's Name (First,	Middle, Last)			νΛE	LIAHOU		me (First, Middle	, Maiden		JNKNOWN)
hould d Mer mark matic	오	AGHABABA 19a. Informant's Name/R	elationship (7	Vne Print)				BIBMA		ner City or	·	<u>.</u>
end 2 s end 2 s eelth an n 27 ls i		MASHALAH									, .	, MD 21215
S 1 er item other		20a. Method of Disposition	n		20	b. Place of Disp	osition (Name of ematory or other p	T	Date		cation - City or	
Deficiencies, Maily Jania, 2.12.13-0050 permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelin and Mental Hygiene. Department of Heelin and Mental Hygiene. The mary injury or other traumatic event, the Madical Examinar must be notified at once.		1 XX Burial 2 ☐ Cred 4 ☐ Donation 5 ☐ C			n State	•	ISRAEL (5/2006	ROS	EDALE,	MD
Dall permit. Departr Import any inju		21. Signature of Funeral	Service Licen	9111			22. Name and Add	dress of Facility	OL LEVII	NSON	& BROS	., INC.
0 80E 8 8		west !	1/ U	M	W						SVILLE	, MD 21208
		23a. Part1. Enter the disc shock, or heart failu	re. List only	olications that one cause on	each line.	leath. Do not e	nter the mode of o	tying, such as cardia	ic or respiratory a	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	a			MOMIN					
Examiner			- 1		Rows		TRULTI	IE PILL	TONARY	~	SISEASI	
	ner	Sequentially list conditions, b. Due to (or as a consequence of): cause, Enter Underlying Cause (Disease or injury)										
acuted ind transi	Examiner	Cause (Disease or injury that initiated events c										
icate be executed physicien and sthe burial-transit	E	resulting in death) Last	- 1	Due to	o (or as a con:	sequence of):						
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nding use a	J/Me	IF FEMALE: 23b. Was decedent prega	nant		utcome of pre		□Ectopic pregna			2	3d. Date of de	livery
The law requires that the death certify the law requires that the death certify are has been signed by the ettending page 2 should be deteched for use as	Physician/Me	in the past 12 month 1 ☐ Yes 2 No	1□Live 4□Preg 9□ Unk			Month	Day Year					
d by the	Phys	9 Unknowń							00 5:1			
res th	ρ	Part II. Other significant	conditions of	ontributing to	death but not	resulting in the	underlying cause	given in Part I.		Yes 2		o the cause of death?
w requires been sign should be	etec			_								
VICAL NEC sician: The law s certificate has b lirector, page 2 s	Completed			-					24a. Was		24b. Were at prior to death?	utopsy findings available completion of cause of
VIIAII I ician: Tr certificate ector, pa		25. Was case referred to	medical					Of Plans of Do	1 ☐ Yes	2 No	1 🗆 Yes	2 No
ysicia ysicia is cert	o Be	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1 X	Inpatient	2 🗌 ER/Outpati	ent 3 DOA	Othor	Home 5 ☐ Res		Other (Spe	cify)
ng Phy ng Phy ter thi	Ju: T	27. Manner of Death] Pending	28a. Date (Mo	e of Injury onth, Day Yea	28b. Time	of 28c. Ir	njury at Nork?	28d. Describe			
Attending or death. • Attending or death. • ector; Afte by the fune	catic	2 Accident	investigation Could not be				M 1	☐Yes 2☐No				
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	determined	286. Plac	ce of Injury - A ding, etc. (Sp	At home, farm, s ecify)	treet, factory, offic	СӨ		(Street and wn, State)		ural Route Number,
spital ours a		29a. Certifier 110	Certifying Ph	vsician: To th	ne best of my	knowledge, de	ath occurred at the	e time, date and place	e, and due to the	cause(s)	and manner as	s stated
ne Ho 24 h se Fur	edical	(Check only 2 1	Medical Exan	niner: On the	basis of exan inner stated.	nination and/or	investigation, in m	y opinion, death occ	urred at the time	date and	place, and due	to the cause(s)
To the withing To the comp	ĕ	29b. Signature and title o	f certifier	mall	i. M	۵.		ense number		29d. Date	signed (Mant	h. Day, Year)
		Johna	~ P	11104	111		DH	1410		Jahua	24 02	1 2006.
\		30. Name and address of				Α.		INDER P	MEHTA			
, a		31. Date filed (Month, Da		SPITAL	Registrar's S	ionature		TOWN W	10 ZII	55 -		
Sta Registi			6 2006		Tregistial's 3	K L	ule					
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Amend item#10b-c,perfil,351,1506 11 State of Maryland / Department of Health and Mental Hygiene 1 1 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Januar JAMES E. KING 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NIA Agnes saltimore HUSPITAI 5. Social Security Number If Under 1 Year Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09. 17. 1946 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 **⊠**M 2 □ F 216.42.4472 Yrs. Director NC Usual Residence of Decedent 10c. City, Town or Location
Catonsville 10a. State 10b. County 10d. Inside City Limits il Hygiene i other then "natural", or fleme 23a or 28a-f ehow vent, the Misdical Exeminar mush be multifed at Baltimore 1 XYes 2 No Completed by Funeral Director MD 10e. Street and Number 10g. Citizen of What Country? 1801 MAIN CIRCLE 21228 FALLS USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 end 2 should be filled within 72 hours after onent of Health and Mental Hygiene.
ant: If Item 27 ie marked other then "natural", or iten 1/17 or other traumatic event, the Modical Exemptor 1 Never Married 25 Married 21215-0036 1 ☐ Yes 2 K No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED TRANSPORTATION 12/H GRADE NA Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELIAS KING EUNICE MAE HILL ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSEMARY KING CHIFE MAIN FALLS CIR. CATONSVILLE, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 4 □ Donation 5 □ Other (Specify) KING PARK RANDAUSTOWN, MD 01.07.06 21. Signature of Funeral Service Licens VAUGHN C. GREENE FUNERAL SERVICE Vangh 5151 BALTO. NATE PIKE, BALTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death myocardial acute unknown Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine physicien end s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending pl for use as t Box IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ned by the a P.O. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 2□ No 1 Yes 2 4 No 1 TYes B Hospitel or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one | examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ۾ within 24 hours after To the Funerei Direct 4 - Homicide filled in 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47353 January 2,2006 who completed cause of death (Item 23a) (Type, Print) 900 Caton Nenue Buthwork, Muyland 30. Name and an ress of pers 7 where 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 5 2006 Registrar

			1- State of Maryland Registrar	-	artment rtificate			ind M	_	giene Reg. No.	06	00073
	Physici	an	1. Decedent's Name (First, Middle, Last)						Date of De Month	ath Day	Yeer	3. Time of Death
	/Medic		Susie Ree Krick						1-1-	2006		3:55 A M
4	Examin	er	4a. Facility Name (If not institution, give street and number)		1		Location o	f Death			ounty of Death	
			Augsburg Lutheran Home			ynn		Od Usa			altimo	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 ★ 7. Age (In yrs. last	Yrs.	If Under Months	Days	If Under a	Min.	8. Date of Bin (Month, Da 8-24-1	th y, Year) 917	9. Birth Cou M	place (State or Foreign untry) D
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	own or Lo	cation							10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: it item 27 is marked other than "naturat', or items 23e or 28e-f show any injury or other traumatic event, the Medical Evantinar must be routlind an ODGe.	by Funeral Director		Burr								1 ☐ Yes 2 ⊋No
	iff the	i.e	10e. Street and Number		10f. Zip					10g. Citize	n of What Cou	untry?
	ath w	la	7100 B&A Blvd.		2106					U.S		
	tams er m	ne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Deced f Yes, spec	ent of History	spanic Orig n, Mexican	gin? (Sp <i>e</i> , Pu <i>er</i> to F	cify Yes or No Rican, etc.)	- 14.	Race - Amer Black, White	
36	s afte	Y	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:		1□Yes 2	2⊠ No	Specify:			S	pecify: W	hite
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	Hyg Hyg other		17. Father's Name (First, Middle, Last)			T	18. Mothe	r's Name	(First, Middle,			
an	ld be ental ked o	To Be	Neal Johnson				Sus	ie Ba	iley L	angfo	rd	
Maryland	shou nd M mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address	(Street a	nd Numbe	r or Rurai	Route Numbe	er, City or T	own, State, Z	ip Code)
Ž	od 2		Mr. Charles Krick / son	773 I	obbin	Cou	ırt: S	Sever	n, MD	21144		
ē,	f Healthan		20a Method of Disposition 20b. Place	e of Dispo	sition (Nam	ne of			ate		tion - City or T	Town, State
30	ages ant of nt: tf		TXDBurial 2 Cremation 3 Hemoval from State		n Men		1	1-4-	2006	Glen	Burni	ο MD
Baltimore,	nit. F artm ortar injui		21. Signature of Funeral Service Licensee				1		gleton			
B	permi Depar Impo any ir		Mark Manuel Mais						en Bur			
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.									Approximate Interval Between
8760,	Physician /Medical Examiner but sician and the prival-transit the prival-transit care from the prival-transit care from the prival from the pr	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Atheroscic (Due to (or as a consequence) or as a consequence). Due to (or as a consequence).	ace of):	Car	2110	JOSE	140	Pise	C1S&		Onset and Death
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ NO 9 □ Unknown 23c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat	ath 3	Ectopic pre					230	d. Date of deliversity	very Day Year
	w requires that s been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying ca	use give	n in Part I.			obacco use res 2 🗆 1		the cause of death?
oro	requi	ted	Hypoalbuminemia					_		185 201	40 3 <u>0</u> Fig	
Rec	sician: The law certificate has b irector, page 2 sl	Completed by	sacral decubitus vicer					_		rmed?	prior to codeath?	opsy findings available ompletion of cause of
ta		e C	25. Was case referred to medical				26 Place	of Death	1 ☐ Yes (Check only o	2 1 No	1 ☐ Yes	2 No
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o	nding tth: :: Afte	atio	1 Defatural 5 □ Pending (Month, Day Fear) 2 □ Accident investigation	Injury	М		' ∕es 2∐N	No				
Division of Vital Records,	or Attar after dea Director in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	a, farm, str	eet, factory,	, office		2	8f. Location (S City or Tox	Street and N vn, State)	lumber or Rui	al Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director.	Medical Co	29a. Certifier (Check only one) 29a. Certifying Physicien: To the best of my knowle control on the basis of examination and manner stated.									
	o the	Me	29b. Signature and title of certifier		29c.	. License	number			29d. Date s	igned (Month	Day, Year)
	F 5 F ŏ		Naven of Balrit, M.	D.	-	000	586	76	2	anua	ry 3,	20.06
•	V		30. Name and address of person who completed cause of death (Item 2: Karch L. Babitt, M.D. 25 Mar	Ra) (Type	Print)							
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signatur	9			1 (/	- 1214	. , , , ,	1 2-14	ΥΥ
	Registr		JAN 0 5 2006	1	and a							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** JANUARY FLORENCE 3 2006 2:35 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner LUTHERVILLE GENESIS BRIGHTWOOD NURSING HOME BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. 8. Date of Birth (Month, Day, Year 03/21/1911 Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 ☑ F 218-07-0747 94 Director MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23s or 28e-f ehov the Medical Examiner must be notified at BALTIMORE BALTIMORE 1 ☐ Yes 2 🔀 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 SLADE AVENUE APT. #215 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Yes 2 No 1 Never Married 2 Married WHITE Maryland 21215-0036 1 Yes 2 No Completed by 3 ☐Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 ASSOCIATE DIRECTOR CHILDRENS CAMP permit. Pages 1 and 2 should be filed Department of Health and Mentat Hyg Important: if Item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY FOX NUDDELMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 SLADE AVENUE APT. #215 - BALTIMORE, MD 21208 MALCOLM KITT / SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH TFILOH CONG. 01/04/2006 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 900 <u> 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final interiosaleicha raidiouscula **Physician** 400 disease or condition resulting in death) /Medical Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): physicien al the burial-1 Physician/Medical ettending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) TYPS 2 No the o. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ tract in Pection 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? demente certificate 1 Yes 2 No 1 ☐ Yes 20No 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 25€No ٩ 2 EP/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 1 Natural 2 Accident 5 Pending Injury 1 Yes 2 No death. М investigation within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281 Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 12564 all 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16565N. Charles St/ Suite 203 Kendaler owlknerms 31. Date filed (Month, Day, Year) Registrar's Signature 32. State Registrar

ORIGINAL

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		For State Registrar	State	of Marylar		artment rtificate			and Me	ntal H	ygiene Reg. No.	006	00075
Physic /Med		1. Decedent's Name (First, Mid Helen A. Kirl								Date of Date o		2006 ^{Year}	3. Time of Death 7:10 р м
Exam		4a. Facility Name (If not institut Stella Maris	-	umber)		4b. City, T Timo		Location of	of Death			County of Dea	
Funera Directo		5. Social Security Number 213–26–9243	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 75	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.		Birth Day, Year)	C	thplace (State or Foreigr ountry) aryland
ith the Maryland or 28a-f show	Director	10e. Street and Number	ford	10c. C	ty, Town or Lo	Havre	Code	Grace				zen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☒No ountry?
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1 21215-UU35 led within 72 hours aff lygiene. her than "natural", or nt, tro Medical Exert	Completed	Elementary/Secondary (0-12 12 years) (1-4or 5+)	(Give	kind of work DO NOT use fting	done d retired)	uring most Lneer			co	mmunic	,
Maryland d 2 should be file th and Mental Hy ?? Is marked oth traumatic event	To Be	17. Father's Name (First, Middle John Gutowsk							en Dr		le, Maiden	Sumame)	_
Mal nd 2 sho alth and 27 is main in traumi		19a. Informant's Name/Relatio Douglas Kirb			19b. Mailii 19	ng Address (Agena	Street a Driv	nd Number 7e, H	avre (de Gr	aber, City or	Md. State,	Zip Code) 078
faltimore, rmit. Pages 1 ar spartment of Hea portant: if Itam by injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		State	Place of Dispo cemetery, crei	natory or oth	ner place		Date 1/5/0			cation - City or	
Departitions of the post of th		21. Signature of Funeral Service Butter Co	e Licensee	٥								Air,	Inc. 21014
bayon, incate be executed horizontal manufacture in physician and street burial-transit	ı	shock, or heart failure. U Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. BREA Due to Due to	ST CANC (or as a consect (or as a consect (or as a consect (or as a consect	quence of):								Approximate Interval Between Onset and Death
The COLCAS, F.O. DOX of The law requires that the death certific the has been signed by the attending page 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	1 ☐ Live	utcome of pregn birth 2 Fet mant at time of a	al death 3[Ectopic pre						3d. Date of de Month	livery Day Year
wrequires that we require that been signed b	ğ	Part II. Other significant cond	tions contributing to	death but not re	sulting in the u	nderlying ca	use give	n in Part I.			tobacco u		o the cause of death?
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OT VI Physicia this cer al direct	ToB	examiner?	Hospital: 1		ER/Outpatier			r: 4 □ Nur		5 □ Re	sidence 6		cify) HOSPICE
DIVISION OT VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 Suicide 6 □ Coul	stigation d not be 28e. Plac	e of Injury - At h	28b. Time o Injury	М		at ? ′es 2 □ N	No	Location		d Number or R	ural Route Number,
Hospital or A 24 hours after Funeral Directory filled in by	edical Cert	29a. Certifier 1 X Certif	ring Physician: To the	ding, etc. (Speci	owledge, deat	h occurred a	t the tim	e, date and	d place, and	due to th	own, State)	and manner a	s stated.
To the Hospital or within 24 hours af To the Funeral D	Medi	29b. Signature and title of certr	and mai	nner stated.	augii ail@or in			number	L	at trie time		place, and due signed (Moni	h, Day, Year)
	tate	DR. TARIQ MA 31. Date filed (Month, Day, Yea	HMOOD 230	ose of death (Ite O DULAN Registrar's Sign	EY VAL		. !	rimon.	IUM, 1	1D 21	.093		
Regis		INNO		Curro L	F GOL	482							

DHMH 17 Rev 1/2001

HELEN KIRBY

			1 - State Amend Item 8	State of Maryland / F per FH, G859,09/	epartment of Health and N 13706dhb Certificate of Death	Mental Hygien	006 00076
			1. Decedent's Name (First, Middle, Last)		1 /	2. Date of Death	3. Time of Death
	Physici /Medic		Leo	Ohn	KONOPACKI	JAN- 3	
	Examin		4a. Facility Name (If not institution, give str	eet and number)	4b. City, Town, or Location of Death	The same of the sa	c. County of Death
			8 Tea	Rose Driv	e MIDDLE R	IVER 1	Baltimore
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last bir		8. Date of Birth (Month, Day, Year	Birthplace (State or Foreign Country)
	Director		216-03-5707	1 2□F 90	Yrs. Month's Days Hours Mill.	08/15/1915	MANNAND
Т	Р.		Usual Residence of Decedent	10.0			
	aryla shoy	<u>.</u>	10a. State 10b. County	10c. City, Town			10d. Inside City Limits 1 ☐ Yes 2 🗹 No
	89-1	ctc		core Mia	ddle Kiver		
	or 2	Director	10e. Street and Number	7	10f. Zip Code	10g. Ci	itizen of What Country?
	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show the Medical Eval: It ar must be ricitlified at		8 TEA Rose		21220		U.S.A.
	er de	Funeral		. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	pecify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc.
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	1 ☐ Yes 2. No Specify:		Specify: / 1/2
8	hour turai	be to			Doggdont's House Convention	1 105 1	White
<u>.</u>	n 72 "na	Completed	15. Decedent's Educa (Specify only highest grade	completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 166. P	Kind of Business/Industry
7	with than	m C	Elementary/Secondary (0-12)	College (1-4or 5+)	Machinist	11	lesteral Flectoi
0	filed Hygi other ent, L		17. Father's Name (First, Middle, Last)		a 18. Mother's Nam	e (First, Middle, Maide	n Sumame)
Maryland 21215-0036	d be ental	To Be	Joseph	C. KONOP	Ack Ton	Sophia	+ Demseck
₹	should Ind Men	ř	19a. Informant's Name/Relationship (Type		. Mailing Address (Street and Number or Rul		
<i>®</i>	01 00 -00		Doris K- Ale	Λ	1242 HARBOUI		1.5
ō,	Health Health tem 27 other tr		20a. Method of Disposition	20b. Place of	Disposition (Name of		Location - City or Town, State
<u></u>	Pages nent of int: If It		Burial 2 Cremation 3 Re		y, crematory or other place)	The same of	
altimore,	iit. P artme orten injur.		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 		> tanislans JAN	6,06	ILTIMORE, 1913.
Ba	permit. Departm Importe any inju		Valent 1		JOSEPH NZAN	NINO	· Furenal Home
			23a Part 1 Enter the disease or porpolic	ations that caused the death. Do	2635. Con KII not enter the mode of dying, such as cardiac		Approximate
В			shock, or heart failure. List only one	cause on each line.	1		Interval Between
	Physician /Medical		disease or condition resulting in death)		ascular Acciden	X. (Kecu	errent) 24 hrs
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		5	Sequentially list conditions, I any, leading to mirrodiate cause. Enter Underlying	Dua to (or as a consequence		//	
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687	ficate phys	edicai	d.				
	that the death certifii ed by the attending I detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	eath atter	ciar	in the past 12 months?	1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
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α.	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	/ P	Part II. Other significant conditions conti	ibuting to death but not resulting in	n the underlying cause given in Part It.	23e. Did tobacco	use contribute to the cause of death?
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20	w requir been si should l	ete	- 011-	calal.	V.asculardisease assular Accident	Oda Mhann	Oth Warn automaticalism available
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Vital	ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	spital:	0.4	th (Check only one)	
ot	는 다 등	۲: ۲:	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 2 ER/Ou	itpatient 3 DOA 4 Nursing Ho	ome 5 X Residence 28d. Describe how inju	
	ding h. After fune	tion	1 Natural 5 ☐ Pending		njury Work? M 1 Yes 2 No	20d. Describe now inju	ny occurred
S	deat deat ctor: y the	lica	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, fa		28f Location (Street a	and Number or Rural Route Number,
Division of	after Dire	Certification:	4 Homicide determined	building, etc. (Specify)	in, sires, lacety, office	City or Town, Stat	
	To the Mospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director, I		29a. Certifier Certifying Physi-	cian: To the best of my knowledge	a, death occurred at the time, date and place,	and due to the cause/s	s) and manner as stated
	e Ho: 24 h B Fur etely	Medical	(Check only 2 Medical Examine one)	er: On the basis of examination an and manner stated.	d/or investigation, in my opinion, death occur	red at the time, date an	nd place, and due to the cause(s)
	vithin orth	Me	29b. Signature and title of certifier	1	29c. License number	29d. Da	ate signed (Month, Day, Year)
	->-0		1 illine	the (+	1.D.) D-1799	2	01/04/21
	1		30. Name and address of person who com	pleted cause of death (Itam 23a)		2	106
	Y		KITN M.	TUN 1312	goucher BLU	1 Towson	J MD 7 12.86
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Signature	0		114 2,00
	Regist		JAN Q 4 2006	Breeze St.	Coule		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year 01/03/2006 12:20 Esther Isabell Klein /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bowie Prince Georges 12208 Madeley Lane | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Manth, Day, Year) | 06/26/1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F 80 Director 204-14-9730 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28e-f ehow permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturel", or Items 23a or 28e-1 ehow emy injury or other traumatic event, the Medical Exact the mural be published. 1 XYes 2 No Maryland Prince Georges Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12208 Madeley Lane 20715 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Prince Georges Elementary/Secondary (0-12) College (1-4or 5+) Cook County Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wade Hampton Lightner Mable Alveeda Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Lee Miller/ Daughter 1016 Leonard Berrier Road Lexington, NC 27295 20b. Place of Disposition (Name of cometer, crematory or other place)
Arlington
National Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/11/2006 Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** repais week /Medical Due to (or as a consequence of): Examiner Aspiration neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (r as a consequence of): Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a Division of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Advanced Dementia 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1□ Yes 1 Yes 2□ No rs after deau...
rel Director; After this cer...
rel in by the funeral director, pr 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Ø Residence 6 ☐ Other (Specify) 1 ☐ Yes 🔀 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funarel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 in Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D&6199 JONUA 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2191 Defense Highway Suite 201 Crofton, MD 21114 Emily Ulmer, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 4 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** January 1, 2006 6:30 A M Frances Η. Knott /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Towson

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Aligust 17, 1923 Manor Care Ruxton Baltimore 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F 82 Yrs. Maryland Director 220-14-1222 Usual Residence of Decedent with the Maryland 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits d other then "naturel", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 Yes 2 No Maryland Baltimore Parkton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 801 Miller Road 21120 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 Mo If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ZXNo Specify Specify: White þ 3₹Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Inspector Silver Production 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Item 27 is marked o Pages 1 and 2 should be Ebbert Helen Rice William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Charlene Knott 801 Miller Road Parkton, Maryland 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of H Important: If Its any injury or of 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 1/4/2006 Woodlawn Cemetery Woodlawn, Maryland ²² Name and Address of Facility
Burrer—Henss—Seitz Funeral Home, Inc.
3031 falls Koau, Baltimore, Flarylanu 21. Signature of Funeral Service Licensee 21211 W 0 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Years Examiner SIrolas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospitel or Attending Physician: The law requires that the death certificate be executed and physician ar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) the the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 has certificate director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this After thi funeral of 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Yeer) Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 □ Yes 2 □ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours at To the Funeral D 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Chack only onel 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D-0012849 30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print) OSLER Dr. TOWSON MD 21204 GHILADI, M 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State Registrar JAN 0 3 2006

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			For State Ragistrar	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•	e of Death	Reg.	2000	000/9
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign untry)
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	yland		10a. State 10b. County	10c. City, T	Town or Location				10d. Inside City Limits
	Ba-f sl	Director	MD Harford	4 Fo	PREST H	111			1 ☐ Yes 3€ No
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-215	within 72 ene. than "na' he Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of wo	ork done during most of wor ise retired)	king	b. King of businessi	industry
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and	I be fil ntaf H ed ott	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, Mai	iden Sumame)	
Maryland	should and Men marke umatic	으	19a. Informant's Name/Relationshii (Typ	pe, Print)	19b. Mailing Address	(Street and Number or Ru	ral Route Number, C	ity or Town, State, Z	(ip Code)
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e e	Pages 1 and neut of Healunt: If Itam		20a. Method of Disposition 1) Burial 2 Cremation 3 Re	cem	e of Disposition (Na netery, crematory or o	me of other place)	Date 200	c. Location - City or	Town, State
Ē	글 문란를 .		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Garde		Address of Earling Co.	6,200 K	osedale,	Maryland
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	the H hin 24 the F mplete	Medical	one)	and manner stated.		c. License number	,	Date signed (Month	
GC.	Veil To		29b. Signature and title of certifier	Heg Naget - P	115.	0059387		1/3/05	·, ouj, 1041)
	λ		30. Name an address of person who cor	mpleted cause of death (Item 2	3a) (Type, Pri	p 11	3 125-5-11413		
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	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	Acrobi S	;			

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Physicia								Month	Day	Year	6.00 PM
/Medic Examin	100	Betty Ann Luttrel. 4a. Facility Name (If not institution, give stre				4b. City, Town, o	r Location of Death		4c.	County of Deat	
Examili	ا5 د		are H	0501	tal	Rose	dale		F	salti	more
Funeral		Social Security Number	7. Age	e (in yrs. last b	oirthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	irth	O Diel	nplace (State or Foreign untry)
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and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
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the routil	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Co	untry?
		2106 Sunnythorne Ro	ad			21220				U.S.A.	
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1 and 1 Health 1em 27		Randy Luttrell, Sr.	(Son)			Sunnyth	orne koac	l, Balti Date	,		and 21220
permit. Pages 1 an Depertment of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □ Ren	noval from State	ceme	tery, crei	matory`or other pla	· 1			ocation - City or	
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ires tha signed be det	þ	Part II. Other significant conditions contri	buting to death b	ut not resulting	g in the u	inderlying cause giv	ren in ⊬aπ i.				the cause of death?
w require been si should t	Completed							A 400 A 400 A			
has ge 2	ld m							24a. Wa aut	is an opsy formed?/	prior to death?	topsy findings available completion of cause of
sician: Th	e Co	25. Was case referred to medical					00 Di (D	1 Yes		1 Tes	2 No
ysician: The l is certificate ha director, page	O B	examiner?	spital: 1 Inpatie	ent 2 ER/	Outpatie	nt 3 DOA Ott	26. Place of Dea			6 ☐ Other (Spe	cufu)
g Phys er this eral dii	n:	27. Manner of Death	28a. Date of Inju (Month, Da		o. Time o			28d. Describe			ony
or Attending Phater death. Director: After the in by the funeral	Certification:	2 Accident investigation	(MOIIII, Da	y rear/	Injury		Yes 2 □ No				
r Atte	t t t t t t	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj	ury - At home, c. (Specify)	, farm, st	reet, factory, office			(Street ar		ural Route Number,
ral Differ											
To the Hospital or Attending Physician: within 24 hours after death as a first death or To the Funeral Director: After this certifics completely filled in by the funeral director; it	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	r: On the best r: On the basis o and manner st	f examination	dge, deal and/or in	th occurred at the till estigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time	e cause(s e, date an	i) and manner as d place, and due	stated. to the cause(s)
o the othe	Med	29b. Signature and title of certifier / /	and manner su	ateu.		29c. Licens	se number		29d. Da	ite signed (Mont	h, Day, Year)
F ₹ F 8		1/1/	11-			DE	5-00	0			
1		30. Name and address of person who com	pleted cause of c	death (Item 23	a) (Type	Print)			/_	, - 0	
6		Dr. Minus Vas		05 90	200 F	panklin	Square	Dave	Ba	It mou	, md 2123
Sta		31. Date filed (Month, Day, Year)		rar's Signature	1	M. P.	1-0-1-				,

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of M	Maryland /		artment of F		and Mer	_	giene	006	00	0082
I	Physicia /Medic	ai .	Decedent's Name (First, Middle VATH 4a. Facility Name (If not institution	A LEWAN			4b. City, Town, o	r Location o	V	Date of De Month	Day	Yea 2 County of Do	064	ime of Death
	Examin	· .	HARBOR HOSP.	ZTAL-			BA	ALTI	HOR			County of Di	-	
	Funeral Director		5. Social Security Number 217–38–5291	6. Sex 7. A 1 ☐ M 25€ F	Age (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Min.	Date of Bir (Month, Da 06/1	th ly, Year) 3/19		Country)	State or Foreign
	Maryland f show	ō	Usual Residence of Decedent 10a. State 10b. County MD	N/A	10c. City, To	wn or Lo		more	City					ide City Limits
	with the last or 28e-	Direct	10e. Street and Number 1329 Richardson	n Street			10f. Zip Code	230	-		_	zen of What		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural; or iteme 23a or 23a-f show aimportant: if item 27 is marked other than "netural; or iteme 23a or 23a-f show aimportant; if item 27 is marked other than "netural" or 200 is a proper or 200 is a pro	by Funeral Director	11. Marital Status 1 Never Married 2 Married 2 Married 2 Married	12. Was Deceder Armed Forces 1 ☐ Yes 2C If Yes, Give Year or Date	s? ∑ No	ĺ	Was Decedent of H f Yes, specify Cub l □ Yes 2∑No	lispanic Ori an, Mexican Specify:	gin? (Specify , Puerto Ric	y Yes or No an, etc.)	-	14. Race - Al Black, W	merican Indi hite, etc.	
21215-0036	thin 72 hours e. an "netural" M. cical Ex	Completed b	3 Widowed 4 Divorced 15. Decedent (Specify only highes Elementary/Secondary (0-12)	t's Education	16	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most	t of working			nd of Busine	whit ss/Industry	.e
nd 21	oe filed withing all Hygiene.	Be Con	10 17. Father's Name (First, Middle, Alexander Spara				Clerk		or's Name (F			e Insi	urance	2
Maryland	should be and Mental s marked o	ပို	19a. Informant's Name/Relations Judith Ann Lewar		19	9b. Mailir	ng Address (Street		hia Ne		er, City or	Town, State	e, Zip Code)	
	s 1 and 2 f Health a frem 27 is other trai	1	20a. Method of Disposition		20b. Place	of Dispo	WOODALL sition (Name of natory or other place	1	t, Bal			21230 cation - City	_	
altimore,	nit. Pages artment of I ortent: if it injury or or injury or or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S) 21. Signat value Funda Suice	(pacify)	" Glen	ı Hav	ren Cem.	Janua	ry 4,	2006	Gle	n Burr	nie, M	D
Ba	permit. Departr imports any inj		21. Signal to d. F. room to the 21. Signal to d. F. room to the 23a. Part 1. Enter the disease, or				1301 Eas	L FOI	C Aver	iue, r	MILL	ome,] more N	צו צ עני	30 eximate
	Physician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aa	ı line.	UCE	R LOZ					A STASI	Interv Onset	al Between at and Death
,	icate be executed physicien and s the burial-transit	Examiner	Social daily list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	as a consequence									
68760,	rtificate b ng physic as the b	Aedica	IF FEMALE.	d										
.O. Box	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as it.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown		2 Fetal dea at time of death		Ectopic pregnancy Other (specify)	′			2	23d. Date of o Month	delivery Day	Year
<u>α</u>	w requires that been signed b should be deta	by	Part II. Other significant condition	ons contributing to death	n but not resulting	j in the u	nderlying cause giv	en in Part I.			_	se contribute		se of death?
Vital Records,		Completed								24a. Was auto perfo 1 Yes		24b. Were prior to death	to completion	dings available n of cause of
of	ding Physician: The k h. After this certificate ha funeral director, page 2	on; To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No 27. Manner of Death 1 ☑Natural 5 □ Pendin	Hospital: 1 Inpa		Outpatien Time of		er: 4 🗆 Nu	7		dence 6	Other (S	pecify)	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	2 Accident investig 3 Suicide 6 Could of determine	not be 28e. Place of I	Injury - At home, etc. (Specify)	farm, str		Yes 2□	-	Location (City or To		d Number or)	Rural Route	o Number,
	e Hospits 24 hours e Funeral etely filled	edical C	29a. Certifier 1 Certifyin (Check only 2 Medicel one)	ng Physician: To the be Examiner: On the basis and manner	s of examination a	ge, death and/or in	n occurred at the tir vestigation, in my o	me, date an pinion, dea	d place, and th occurred a	I due to the at the time,	cause(s) date and	and manner place, and o	as stated.	tuse(s)
ł	To the within 2 To the Complet	Me	29b. Signature and title of certifie	// .			29c. Licens	e number	0		_	e signed (Mo		
	0,		30. Name and address of person	who completed cause of	of death (Item 23a		-				JANU	any 1	1 200	06
	Sta	te	LAY KHIN . 36 0 1 31. Date filed (Month, Day, Year)		TANOVEI strar's Signature	2 ST	, BALTI	MORE	5) M	D212	15			
	Registr		JAN 0 6	2006	12 14	Col	w							

			For State Registrar	State of Mar		epartme Certifica			and Me		jiene	006	00083
18.00 18.00 18.00	Physicia		Decedent's Name (First, Middle, Last) DECCY, T.EE, T.AVICE	COUNT					_	2. Date of Dea Month	Day	Year	3. Time of Death 10:35 AM
	/Medic Examin		PEGGY LEE LAVIS 4a. Facility Name (If not institution, give s			4b. Cit	, Town, or L	ocation o		anuary	02 4c. Cd	2006 ounty of Death	
		A	St. Agnes Hospis 5. Social Sacurity Number 6. Sex		(In case In a b bindh		altimer 1 Year	ore If Under:	City	Data of Bigh		N/A	
.5	Funeral Director		,	M 2TF	In yrs. last birtho	Months		Hours	Min.	Date of Birth (Month, Day)	, Year)	COL	place (State or Foreign intry) TH CAROLINA
0-225	and w		Usual Residence of Decedent 10a. State 10b. County	1	loc. City, Town o	or Location							10d. Inside City Limits
	Maryl B-1 sho	tor	MD. N/A		BALTIM	ORE							1X Yes 2 □ No
	vith the	Director	10e. Street and Number	·			ip Code			1	l0g. Citizer	n of What Cou	intry?
13	heath v	Funeral	2201 ROSLYN AVE	2. Was Decedent Ev	er in U.S.		1216 edent of Hist	panic Ori	gin? (Speci	ify Yes or No-	US.	A Race - Ameri	ican Indian.
ر الا	or iter	/ Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, sp 1 ☐ Yes	ecify Cuban,	Mexican Specify:	, Puerto Ri	can, etc.)		Black, White,	, etc.
vìSCoun 21215-0036	within 72 hours after death with the Maryland ene. Then "natural", or iteme 23e or 28e-f show he Maaicel Exeminer mast be notified at	ed by	3 ☐ Widowed 4 ▼ Divorced 15. Decedent's Educ	Year or Dates:	16a. D	ecedent's Us						of Business/Ir	
SC 215	ithin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(9	Give kind of vife. DO NOT	vork done du	ring mos	t of working	7			
> W	filed w Hygier ther th	Cor	-12-	-0-	CO	ACH CI		I8. Mothe	er's Name (First, Middle,		TRAK	
Tan la	2 should be filed within 72 hours and Menial Hygiene. Is marked other then "natural", aumatic event, the Modical Exa	To Be	MACK JONES						,	Y FULLE			
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Healith and Mental Hygiene. I the first them 23s or 28s-1 show fem 21s narked other then "natural", or items 23s or 28s-1 show other traumatic event, the Modical Examinar most be notified at		19a. Informant's Name/Relationship (Type SEAN HUGHES (SON			-					-	own, State, Zi AND 21(
	s 1 and f Health item 27 other tr		20a. Method of Disposition		20b. Place of D		ame of		Da:			tion - City or T	
Peggy Baltimore,	Pages ment of I ant: if its ury or o		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		WOODLAW	-		j j	1-7-20	006 E	BALTI	MORE, N	MARYLAND
Palt Part	permit. Pages 1 and 2: Department of Health ar Important: if item 27 is eny injury or other trau		21. Signatur Free Eral Service License	O CATALAN C	D, HIBN								YLAND 21217
	E		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the	ne death. Do no							E, MAKI	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Subarach	1 1	denor	happ.						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a):	7						
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
· de	cate be executed physicien and the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a	consequence of):							
8760,	cate be e. physicien the buria	dical E	U ₀										
9		/Med	IF FEMALE:	3c. If yes, outcome of	oregoana.								
. Во	death certifi e ettending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live birth 2 4 Pregnant at tir	☐ Fetal death	3 ☐Ectopic 5 ☐ Other (230	d. Date of deliv Month	very Day Year
P.0	uires that the death signed by the etter Id be detached for u	Phys	9 Unknown	9□ Unknown						22 214			
Division of Vital Records, P.O. Box	or Attending Physician: The law requires that the death certificated death. Director: After this certificate hes been signed by the ettending in by the funeral director, page 2 should be detached for use as	d by	Part II. Other significant conditions con	induling to death but	not resulting in t	ne underlying	cause given	in Part I.			es 2 🏋		the cause of death? babby 4 Dunknown
600	law requir es been si 2 should	Completed								24a. Was a		24b. Were auto	opsy findings available ompletion of cause of
a R	icete h									perfor	med? 2 X No	death?	
ξ.	/siciar s certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 M No	ospital:	2 ER/Outp	atient 3 🗆 [Other			Check only or		Other (Speci	(4.)
n of	ding Physician: The lav h. After this certificete hes funeral director, page 2	on: T	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day)	28b. Tir	ne of ury	28c. Injury a Work?	at	28	d. Describe h			114)
risio	Attendi death. ctor: A y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	v - At home, farn	M n. street, facto		es 2 🗌		f. Location (S	treet and N	Number or Rur	ral Route Number,
Div	tal or / rs after al Dire	Cert	4 Homicide determined	building, etc.	(Specify)		.,,,			City or Tow			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only one)	icien: To the best of e er: On the basis of e and manner state	xamination and/	death occurre or investigation	on, in my opi	data an nion, dea	d place, an th occurred	d due to the c f at the time, d	aut a(t) ar late and pl	d mannar as a ace, and due l	etatled. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	A 1	^		9c. License		- n 0	k	29d. Date s	signed (Month,	, Day, Year)
	/		20 Name and address of assessment		U ,		P /	77	U 8	J	anvar	y, 02,	2006
	5		30. Name and address of person who co	00	700 C	ATON	AVE	-202	BAL	TIMOR	EN	10 2	1229
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 6 200	32. Registrar	's Signature	SPACE!							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** JASPER LOWERY 22.00 04 kinuan 2006 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospita 16. Sex Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1∏M 2□ F Director 251-42-5479 Usual Residence of Decedent 76 12-10-1929 SOUTH CAROLINA 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at Director 1 Yes 2 □ No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21229 21 N. HILTON ST. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 | Yes 2 | No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married ō Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK ģ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. -8-DRIVER other AIRPORT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be find and Mental H permit. Pages 1 and 2 should be Department of Health and Mental Important: If Hem 27 is marked any injury or other traumatic events. BUBBA LOWERY ODESSA ANTHONY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET LOWERY (WIFE) 21 N. HILTON ST. BALTIMORE, MARYLAND 21229 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🔀 Crematio 3 Removal from State 4 Donation 5 ☐ Othey (Specify) ARBUTUS MEMORIAL PARK 1-7-2006 BALTIMORE, MARYLAND 21. Signature of Funeral Pervice Licenses JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw shook, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Hyperkalemia Duglokor as a consequence of): Physician day /Medical Examiner Acidosis Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Ischemi or Attending Physician: The law requires that the death certificate be executed Coliti Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 **X**No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပ 1 X npatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After s after dea. rel Director: After 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -19509 Medical Doctor January 04 2006

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State

Ave

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Caton

Hasan Ozdegimena Jou Lund, Annth Day, Dar) 32. Registrar's Signature

6 2006

JAN 0

		i	For State Registrar		partment of Health and ertificate of Death		iene	00085
	VA 1/8	9	1. Decedent's Name (First, Middle, La	51)		2. Date of Deat Month	h Day Ye	3. Time of Death
	Physicia /Medic		William	James	Lee	01		06 8:45a M
	Examin		4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Deat	h	4c. County of C	
100			3619 Wabash Av	e	Baltimore			
	Funeral		Social Security Number 6. S	ex 7. Age (In yrs. last birthd	Months Days Hours Min.		Year)	Birthplace (State or Foreign Country)
8.	Director		219-16-4576 Usual Residence of Decedent	X1M 2L1F 80 Yrs		09 29	25	
	and		10a. State 10b. County	10c. City, Town or	Location			10d. fnside City Limits
	Manyl f aho	5	MD	Dollain	0.000			1 X Yes 2 ☐ No
	the f	Director	MD NA 10e. Street and Number	Baltin	10f. Zip Code	1	0g. Citizen of Wha	t Country?
	with With							
	leath	by Funeral	3619 Wabash Av	12. Was Decedent Ever in U.S.	21215 3. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	U.S.A	American Indian,
· O	r ttar	ᆵ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, V	Vhite, etc.
8	urs a	þ	3 Widowed 4 ☐ Divorced	If Yes , Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify:	Black
9	filed within 72 hours after death with the Maryland Hygiene. sthar than "natural", or trams 23a or 28e-f ahow ant, the Modical Examical must be notified at	Completed	15. Decedent's E	ducation 16a. De	cedent's Usual Occupation ive kind of work done during most of wo	rkina	16b. Kind of Busin	ess/Industry
7	thin e	nple	Elementary/Secondary (0-12)	Coflege (1-4or 5+)	e. DO NOT use retired)	rking		
2	ed wi	Co	llth grade		onstruction Work			ction Co.
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, I	Maiden Sumame)	
yla	Men Men arka	ဥ	Hardy R. Lee		Stener	Heath		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28e-f ahow any injury or other traumatic avant, the Modical Examination in at the notified at once.		19a. Informant's Name/Refationship (Type, Print) 19b. M	ailing Address (Street and Number or R	ural Route Number	, City or Town, Sta	^{te, Zip Code)} 21215
2	and ealth m 27			-Brother-In-Law	3600 Cedardale			Balto, Md
Baltimore,	of H of H if ital		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	comoton	sposition (Name of crematory or other place)	Date	20c. Location - City	y or Town, State
Ē	Pag ment ent: ury c		4 Donation 5 ☐ Other (Special		Blawn 1/7/	/06 E	Baltimor	e Co, Md
alt	Depart Depart Import any inj pnce.		21. Signature of Funeral Service Lice	4. 1	22. Name and Address of Facility March F/H West			
ш	205 = 9		in me to	Thumpen	4300 Wabash Ave			id 21215
64			23a. Part . Enter the disease, or com shopk, or heart failure. List only	plications that caused the death. Do not one cause on each line.	enter the mode of dying, such as cardia	c or respiratory arr	est,	Approximate Interval Between
No.	Physician		Immediate Cause (Final disease or condition	. Hypercolcem				Onset and Death
Jan.	_/Medical		resulting in death)	Due to (or as a consequence of):				
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	ם א	Examiner	any, leaving to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	acute ind trans	аш	Cause (Disease or injury that initiated events resulting in death) Last	c				
Ö,	cate be executed physician and the burial-transit	ũ	resulting in deathy cast	Due to (or as a consequence of):				
8760,	ate b hysic the b	dical		⊾ d.				
9	as as	Mec	IF FEMALE:					
Box	ath certif attending for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of Month	delivery Day Year
0	the a	Sic	1 Yes 2 No	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)			July 1 July
<u>o</u> .	a 5 =	Phy		contributing to death but not resulting in th	a undahing sausa guas in Dari I	220 Did to	haasa usa saatribu	te to the cause of death?
ŝ	w requires that the s been signed by th t should be detache	by	Hyper Tension		e underlying cause given in Fatti.			Probably 4 Qunknown
9	requi	tec	Discerension				53 2 140 5	
ec	(0) 22 (1)	nple	MASETES			24a. Was a autops	sy prior	e autopsy findings available to completion of cause of
Division of Vital Records,	Th ate pag	Completed	MyporLiPIDE	MIA		perform 1 ☐ Yes		h? Yes 2 No
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			ath (Check only or	re)	
$\frac{1}{2}$	\$ v =	2	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpa			ence 6 Other (Specify)
Ē	ding Phi h. After thi funeral	o	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim	ry Work?	28d. Describe h	ow injury occurred	
sio	Attending r death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be	00	M 1 ☐ Yes 2 ☐ No			
Ξ	l or Attsnafter deat Director:	E	4 Homicide determined		, street, factory, office	28f. Location (S. City or Town	treet and Number o n, State)	r Rural Route Number,
L	pitel or Attanons after deatlers after deatlerel Director: filled in by the		200 00-14-1-1					
	0 4 ± 5 €	edical	(Check only 2 Medical Exa	hysicien: To the best of my knowledge, ominer: On the basis of examination and/o	leath occurred at the time, date and place or investigation, in my opinion, death occ	e, and due to the c urred at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
	To the Hos within 24 h To the Fun completely	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		9d. Date signed (A	Annth Day Vasel
	5 1 1 5 0 O		255. Signature and title of certifiel	1/4/		-	T ate signed (N	
			mederal B	(c) (hwu)	D50500		lanuary 5	2006
1	0 "		C = 1 - 0 11 -	completed cause of death (Item 23a) (Ty	SMEET BALTIMON		1400	121
			31. Date filed (Month, Day, Year)	Paristrar's Signature	SINCEI PATTIMOR	c, mony	LITTUD 2	1401
7	Sta Regist	ate rar	100 1 5 20	Registrar's Signature	DEAGLE			
IN.			17. (1.17.11)	UU PROPERTY S				

			- For Stata Amend Item/19	State of Marylan b per FH G851	d / Departme 1/5/06 CO	nt of Health and te of Death	Mental Hyg	iene 0 0 6	00086
K.	Physici /Medic		1. Decedent's Name (First, Middle, Last)				2. Date of Deal Month		3. Time of Death A 9:45 M
	Examin Funeral Director		4a. Facility Name (If not institution, give s 92	per St.		y, Town, or Location of Deat Control Foundary Foundary	e	Year) Co	h Applace (State or Foreign untry)
	with the Maryland a or 28a-f ehow	ctor	10a. State 10b. County NA		y, Town or Location	re			10d. Inside City Limits 1 → Yes 2 □ No
9	death	Funeral Director		2Der Stree 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 02 No	.S. 13. Was Dec	Zip Code 2 20 5 sedent of Hispanic Origin? (\$ pecify Cuban, Mexican, Puer		0g. Citizen of What Co	ncan Indian, a, etc.
15-0036	72 hours after "natural", or ite	leted by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade		16a. Decedent's U:	work done during most of wo	rking	Specify: 16b. Kind of Business/	Industry
d 2121	e filed withir Il Hygiene. other then	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life. DO NOT	stodian	me (First, Middle, F	School Maiden Sumame)	
Maryland	s 1 and 2 should be filed withi f Health and Mental Hygiene. Item 27 is marked other ther other traumatic event, the M	To B	Charles 19a. Informant's Name/Relationship (Ty)	Jackso po, Print) nieces	19b. Mailing Add e	D O	roth L	City or Town, State, 2	SON (ip Code)
	e = 5		NS. Bertha L. 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ R	1 ,	Place of Disposition (A	lame of rother place)	Date	St.Balto. 20c. Location - City or	
Baltimore	permit. Pag Department Important: I eny injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service (Cense	L Rus	1/1+, Z10 22. Name 1/2227	and Address of Facility 3		Russ Fu Baltimor	
8760,	Fequires thet the death certificate be executed By the attending physician and signed by the attending physician and the detached for use as the burial-transit	dical Examiner	23a. Part / Enter the disease, or compile short or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	tence of):				Approximate Interval Between Onset and Death
P.O. Box 6	the death certifica y the attending ph ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3 Ectopic			23d. Date of deli Month	very Day Year
	w requires thet the de been signed by the a should be detached t	ed by Ph	Part II. Other significant conditions con	utributing to death but not res	ulting in the underlying Alcolo	cause given in Part I.		pacco use contribute to	the cause of death?
Division of Vital Records,	The law ate has b page 2 si	Completed by	Atual Fibrill	ason, Mr	25A Sep	sis	24a. Was all autops perform	y prior to d	topsy findings available completion of cause of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		Othors	ath (Check only on	е)	
of	Phy this raid	T.	1 ☐ Yes 2 ☐ No ☐	1 Inpatient 2	ER/Outpatient 3 1			ence 6 Other (Spec	cify)
ision	ding After fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year)	Injury M	28c. Injury at Work? 1 Yes 2 No		reet and Number or Ru	m Pouto Number
Div	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the		4 Homicide determined 29a. Certifier 1 Certifying Physics	building, etc. (Specif	y)	ad at the time, date and place	City or Town	n, State)	stated
	the Ho nin 24 h the Full npletely	Medical	(Check only 2 Medical Examination)	ner: On the basis of examina and manner stated.	tion and/or investigation	on, in my opinion, death occu	urred at the time, da	ate and place, and due	to the cause(s)
	To the vithing of the comp	Σ	29b. Signature and title of certifier	n.D.		9c. License number 3508 2		9d. Date signed (<i>Mont!</i> 1/5/06	n, Day, Year)
	4		30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type, Print)	lucie, m	771224	1	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa		s.		•	

State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Orville Burgan Lescalleette 1-1-2006 4:45 A M /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Mariner Health of Glen Burnie Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-22-1912 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax Birthplece (State or Foreign Country) **Funeral** Hours 1 M 2 □ F 216-09-9937 Director MĎ 93 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s t and 2 should be filed within 72 hours after deeth with the Marylar I Health and Mental Hygiene. I Health and Mental Hygiene there 23a or 28a-f show other traumatic event, the Medical Examinational terrolling at the resulting at Director 1 ∏Yes 21⊠ No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1540 Colony Road 21122 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2¥QXNo White Specify þ 3X Widowed 4 ☐ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Postal Worker U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Lescalleette 2 Katherine Gauker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages t and 2 st ment of Health and tant: If item 27 is r Mrs. Claudia Garland / Daughter 1540 Colony Road; Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. *4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery Gwynn Oak, MD 1-5-2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 ant. 1031357 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or unit failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner transit be executed and burial-t Due to (or as a consequence of) Box 68760 the attending physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Vear Day 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 Yes 2 No Division of Vital To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 1 1 Pring Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Matural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 within 24 hours a To the Funeral D Hospital 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29b. Signature and titl + of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32 Registrar's Signature South Registrar

ORIGINAL

			For State Registrar	State of Marylan	-	artment of h		Ť	giene	6 (00088
	Physicia	an	Decedent's Name (First, Middle, Last					2. Date of De Month	Dav	Year	3. Time of Death
	/Medic	al	Jerome John 4a. Facility Name (If not institution, give	Lapinski		4b. City, Town, o	v. Location of	January	4c. County	006	2:55 PM
	Examin	er	7840 Elizabeth				asadena		-	ne Ar	undel
to the second	Funeral		5. Social Security Number 6. S	***		If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bir Min(Month, Da	10 1952	9. Birthpla	ace (State or Foreign
	Director		213-60-0646 ¹ Usual Residence of Decedent	WW 201	3 Yrs.			June 2	26 1952		
Vland	Mot W		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits
Mar	la-f s	ctor	Maryland Anne A	rundel		Pas	adena				1 ☐ Yes 2 🕱 No
with th	be no	Funeral Director	10e. Street and Number	Dood		10f. Zip Code	2112	22	10g. Citizen of V		ry?
eeth	ne 234	eral	7840 Elizabeth	KOd U 12. Was Decedent Ever in U	.S. 13. V	Was Decedent of H				USA e - America	an Indian
USO urs after o	of Heelih and Menial Hygiene. Itam 27 is marked other then "natural", or itame 23s or 28s-f show other treumatic event, If a Medical Exantrat must be notified at	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		I Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, i Specify:	n? (Specify Yes or No Puerto Rican, etc.)	Specify	k, White, e	itc.
2 2 2	natur	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	ation during most o	of working	16b. Kind of Bu	siness/Ind	ustry
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Vialid Suld be til	Mental arked atic ev	To B	John L. La	pinski			Elea	anor A.	Marcis	zewsk	i
Mar d 2 sh	Ith and 27 is m treum		19a. Informant's Name/Relationship (18 Kathryn E. Lapins			-		o <i>r Rural Route Numb</i> Id, Pasader			Code)
ָבְּרְ בְּּ	item item		20a. Method of Disposition	20b. F		sition (Name of natory or other pla		lan. Date 06	20c. Location -		vn, State
Circle Pages	ment cant: if ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nomoval mom State		ary Cemet		2006	Dundalk	, Mar	yland
	Department of Heel important: if item 2 eny injury or other 90ce.		21. Signature of Funeral Service Licen	3001	22	Name and Address 3111 MOU		Stalling Road, Pasa			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the deat one cause on each line.	h. Do not en!	er the mode of dys	ng, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between
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O diffical	ng phy as th		IS SCHALE.								
The law requires that the death certificate be executed	been signed by the ettending physicien end should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3]Ectopic pregnanc] Other (specify) _	4		23d. Dati Mor	e ol deliver nth (y Day Year
T tell so	gned b	by Pr	Part II. Other significant conditions of	ontribuling to death but not res	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	obacco use contr	ibute to the	e cause of death?
	een si							10	Yes 2,KINo	3 Proba	ably 4 □Unknown
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VICAL	certifi	o Be	25. Was case referred to medical examiner? 1 Yes 25 No	Hospital:		Ott	0.00	f Death (Check only o			
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DIVISION 191 per Arrending	rs after de el Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (City or Tou	Street and Number wn, State)	er or Rural	Route Number,
insoH ed	within 24 hours after death. To the Funerei Director: After this certifica completely filled in by the funeral director, I	edical	one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death	n occurred at the ti vestigation, in my	me, date and ppinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as sta ind due to	ated. the cause(s)
Ę	To t	Σ	29b. Signature and title of certifier	Ma	10	29c. Licens	3/5	71	January		
	12		30 Name and address of person who	completed cause of death (Item	7 23a) (Type,	Print	, Dal	Drive (January Le Burn	SA	2106]
	Sta Registr		31. Date liled (Month, Day, Year) JAN 0 3 2001	39. Registrar's Signa	ature	N.	9				1

			1 = For State Registrar	tate of Maryland	•	t of Health and M e <i>of Death</i>	fental Hygien Reg. N	211116	00089
Éz	Physici		1. Decedent's Name (First, Middle, Last)		MUNSO	N	2. Date of Death Month D	3. 2006	3. Time of Death
100	/Medic Examin	100	4a. Facility Name (If not institution, give stree Maryland Gener	at and number)		Town, or Location of Death	ity "	c. County of Death	
1	Funeral Director	Z _I =	5. Social Security Number 6. Sex 1216 - 78 - 73 121 M	7. Age (In yrs. la	ast birthday) If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	hplace (State or Foreign untry) RVLAND
16	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location		100,7		10d. Inside City Limits
	e Maryl	ctor	MARYLAND N/A	7	BAL	TIMORE	CITY		1 ØYes 2 □ No
	a or 24	Funeral Director	10e. Street and Number 2667 SEAMON	1 AVENUE	10f. Zip	2/2 a	2.5 / 10g. c	Citizen of What Co	untry?
	tsms 2	unera	11. Marital Status 12.)	Was Decedent Ever in U.S Armed Forces?	S. 13. Was Deced	ent of Hispanic Origin? (Spirify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
920	772 hours after death with the Maryland "natural", or Itsma 23a or 28a-1 show colcet Externment the ruillish at	þ		I □ Yes 2 2 N o If Yes, Give Year or Dates:	1 ☐ Yes 2	No Specify:		Specify: 3	LACK
215-0036	72 na	Completed	15. Decedent's Education (Specify only highest grade co.	on mpleted)	16a. Decedent's Usua (Give kind of wor life. DO NOT us	k done during most of wor	sing 16b.	Kind of Business/	Industry
212	filed within Hygiene. ther then "	Comp	Elemenţary/Secondary (0-12)	College (1-4or 5+)	7	NTER	54	ELF-EN	PLOYED
and	e d la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last) POSE VEV T		MUNSON	18. Mother's Nam	ie (First, Middle, Maide	n Sumame)	1151
Maryland	2 should the and Ment is marked aumatic a	T ₀	19a. Informant's Name/Relationship (Type,	Print)		(Street and Number or Ru	1 #		
	1 and Health em 27 ther tr		DALLY COLBERT 20a. Method of Disposition		ace of Disposition (Nan		CIRCLE ATT.7 Date 20c.	Location - City or	SWW MD. 21/33 Town, State
Baltimore	0 0		1 ☐ Burial 2 【③ Cremation 3 ☐ Remo • 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	emetery, crematory or of ETRO CRED	ATORY 01-4	06-06 B	ALTIHOR	E MANYLAND
Balt	permit. Pag Department Importent: I sny Injury o once.		21. Signature of Funeral Service Licensee	William	22. Name an	Address of Ficility: 1	BROWN .	JR. FUN BALTO,	MD 21217
100			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications of the Cause (Figs.)	ons that caused the death aus i on each line.	. Do not enter the mod	e of dying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
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	cuted od ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	derice ory.				
68760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):				
_	phy the	Medical	IF FEMALE:						
O. Box	The law requires that the death certificate has been signed by the attending to page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 Ectopic pr			23d. Date of del Month	ivery Day Year
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Vital F		0	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2 121		2 🗆 No
of V	& ≅ ©	ToB	examiner? 1 Yes 2 No Hosp 27. Manner of Death 2	1 Inpatient 2 1	ER/Outpatient 3 DC		ome 5 Residence		cify)
	Attending I ir death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	Injury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	20d. Describe now in	lary occurred	
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	To the Hospitel or Attending Phembin 24 hours after death. To the Funeral Director: After the mpletely filled in by the funeral	edical C	29a. Certifier 11 Certifying Physici (Check only one) 2 Medical Examinar:	en: To the best of my know On the basis of examinat and manner stated.	wledge, death occurred tion and/or investigation	at the time, date and place, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as and place, and due	s stated. to the cause(s)
	To the	Me	29b. Signature and title of certifier	D-dd	290	: License number	29d. [Date signed (Mont	h, Day, Year)
	0		Mulip a 30. Name and address of person-who comp	leted cause of death (Item	7 . 1 23a) (Type, Prilling	3930/	0	12/20	106
			reelina Red	14. M.D.	40 //	cyland (or eral	- 105/	ortal_
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 0 6 2008	32. Hegistrar's Signa	" france				

			1 - State of Maryland / Dep	partment of Health and Nertificate of Death		20006 000	90
	Physicia	an	1. Decedent's Name (First, Middle, Last) Catherine Adele Markel		2. Date of Death Month	Day Year 3. Time	M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Ravenwood Lutheran Village	4b. City, Town, or Location of Death Hagerstown	Janurary	3 2006 8:05 4c. County of Death Washington	PM
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ☒ F 88 Yrs.		8. Date of Birth (Month, Day, Y Aug. 1,	9 Rirthnlace /State	or Foreign
			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	neation		10d. Inside	City Limite
	Maryli -f sho	tor	Maryland Washington	Keedysville			s 2 No
	th the	Director	10e. Street and Number	10f. Zip Code	10g	Citizen of What Country?	
	s 23a	rai	5346 Porterstown Road	21756		u.s.A.	
980	72 hours after death with the Maryland natural; or Items 23a or 28a-f show itsal Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
2-0	72 hours natural', dical Exa	eted	(Specify only highest grade completed) (Gir	edent's Usual Occupation re kind of work done during most of work	sing 16	b. Kind of Business/Industry	
121215-0036	s 1 and 2 should be filed within 72 hr Health and Mental Hygiane. Ifem 27 is marked of the than "natuu other traumatic event, the Medical	Completed	Elementary/Secondary (0-12) 12th Grade College (1-4or 5+)	DO NOT use retired) Homemaker		Own Home	
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lary	2 should be f and Mental H is marked of raumatic ever	-	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rui	al Route Number, C	City or Town, State, Zip Code)	
	1 and 2 Health em 27 i			6 Porterstown Rd.,		LLe, MD 21756 c. Location - City or Town, State	
mor	eg = 5		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, ca	ematory or other place)		altimore, Maryl	and
Baltimore,	permit. Pages 1 a Department of Hea Important: If Item any injury or othe once.			22. Name and Address of Facility Sc	himunek F	uneral Homes	correct .
	Ш.,		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	9705 Belair Rd., nter the mode of dying, such as cardiac			
	Pnysician		Immediate Cause (Final disease or condition	Disease		Onset and	
	/Medical Examiner		resulting in death) Due to fir as a consequence of):				
-		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury				
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68760,	rificate be executed g physician and as the burial-transit	edical E	d				
	ertificat ling phy e as th	Medi	IF FEMALE:	and an analysis of the second		120	
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day	Year
Vital Records, P.	quires that in signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of	death?]Unknown
eco	taw requir as been si 2 should	Completed			24a. Was an autopsy	24b. Were autopsy finding prior to completion of	s available
al B	sician: The law certificate has l irector, page 2 s				performe 1 ☐ Yes 2,9	d? death?	
	Physician: r this certifica ral director, i	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital: 1 □ Inpatient 2 □ ER/Outpat		th (Check only one)	ce 6 ☐Other (Specify)	
n of	ding Phys h. After this fureral di		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how		
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm.	M 1 Yes 2 No		et and Number or Rural Route Nu	mber,
ā	To the Hospital or Attent within 24 hours affer death To the Funeral Director: completely filled i⊨ by the	Cert	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one) Check only one)	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as stated. a and place, and due to the cause	(s)
	To the within ? To the comple	Med	29b. Signature, and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)	
	D		Mangen of suay	D28365	J	annay 4, 200	6.
	10		30. Name and address of person who empleted cause of death litem 23a) (Type MAW 2AR. 2 SH17141 36	D 28365 B. Mell Street TH	egesten	m MO 2/74	2.
	Sta Regist		31. Date filed (Month, Day, Year) 33. Registrar's Signature	rester			

MARKEL, CATHERINE ADELE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland		ent of Health a a <i>te of Death</i>		giene 006	00091
	Dhuaiai		Decedent's Name (First, Middle, Last)	4 -4		2. Date of Dea		3. Time of Death
	Physici /Medio		Reginald		MCKE		Januar	1 1,2000	5 17.29 PM
1	Examin	er	4a. Facility Name (If not institution, give	11	1/a/ 4b. Ci	ty, Town, or Location of	1.1.	4c. County of Dea	ath (A
	Funeral		Social Security Number 6. Se	OKINS HOSPI x 7. Age (In yrs. I		der 1 Year If Under 2	4 Hrs. 8. Date of Birt		rthplace (State or Foreign ountry)
	Director		210-00	2 ^M 2□F 47	Yrs. Month	s Days Hours	Min. Month, Day	1958 M	aryland
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City	/, Town or Location			•	10d. Inside City Limits
	Mary 8-f sh	tor	md. N	7	120	eltim	ore		1 2 Xes 2 □ No
	death with the Maryland rms 23a or 28a-f show rmust be notified at	Director	10e. Street and Number	<i>(</i> -	_ / 10f.	Zip Code 2/23	· · · · · · · · · · · · · · · · · · ·	10g. Citizen of What C	ountry?
	s 23a		229 31	Spring	CT,	212:	5/	707	H
980	is 1 and 2 should be filed within 72 hours efter death with the Marylan if Heelth and Mental Hyglene. Item 27 is marked other than "naturei", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Effr in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	If Yes, s	cedent of Hispanic Orig pecify Cuban, Mexican, 2 2 No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Wh Specify:	
215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Decedent's U	sual Occupation work done during most	of working	16b. Kind of Busines	s/Industry
7	vithin ne. han	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	use retired)	4	FED-	EX
d 21	filed Hygie other	ပိ	17. Father's Name (First, Middle, Last)	4 420:	170		's Name (First, Middle,		
<u>la</u> n	uld be Aental rked c	To Be	Roger mo	NEIL		Lu	cille	Brown	
Maryland	2 should and Mer is marks aumatic		19a. Informan's Name/Relationship (T	*	19b. Mailing Addre	ess (Street and Number	or Rural Route Numbe	r, City or Town, State,	
	1 end 1eelth em 27 ther ti	Щ	Dawn M CN 6 i	L- WIFE	229 _ lace of Disposition (/	S. Spring	Ct. Dal	toind,	
Baltimore,	Pages nent of h int: If ite		1 X Surial 2 ☐ Cremation 3 ☐ I	Removal from State	emetery, crematory of	or other place)	110/06	20c. Location - City o	0
ij	permit. Page Depertment o Important: If any injury or occ.		4 □ Donation S □ Other (Specify, 21. Signature of Juneral Selvice)Licens		17 - 2 Co	and Address of Facility	1	ansdar	
à	90559		Xout 1 11 6	M	Gan	1 1 march	Fineral	Home Bal	10. md. 21229
			23a. Pakt. Ent. the isease, or comp shock, r eart allure. List only of	lications that caused the death	n. Do not enter the m	de of dying, such as o	ardiac or respiratory ar	rest,	Approximate Interval Between
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	/Medical Examiner		ſ	Due to (or as a consequ	Jones org.	art Fai			dan dile
Ŧ	1	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to lor as a consequ		117 rai	1016		7111010110
V	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с					
60,	be exi	E	resulting in death, cast	Due to (or as a consequ	ience of):				
68760,	ificate be executed g physician end as the burial-transit	edical	`	d					
Вох			230. Was decedent pregnant	23c. If yes, outcome of pregna 1 Live birth 2 Fetal				23d. Date of de	alivery
P.O. B	that the death certificate be executed ed by the ettending physician end detached for use as the burial-transit	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de		c pregnancy (specify)		Month	Day Year
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000	ne law re hes bee	Completed					24a. Was	an 24b. Were a	utopsy findings available completion of cause of
œ	The page	Com					autop perfor 1 ☐ Yes	rmed? death? 2 No 1 ☐ Ye	s 2 ANO
Vita Vita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		Other	of Death Check only o		
	Phys ar this aral di	. To	1 12 Yes 2 No 27. Manowr of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 322 28b. Time of	OA Other: 4 Nur 28c. Injury at	sing Home 5 Resid	dence 6 Other (Sp.	ecify)
<u>o</u>	Attending r death.	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ N		,.,	
Division of	ei or Atte s efter de si Directo ed in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al ho building, etc. (Specify	ome, farm, street, fac	ory, office	28f. Location (S City or Tow	Street and Number or F rn, State)	lural Route Number,
	To the Hospitei or Attending Physician: The within 24 hours effer death. To the Funerei Director: After this certificate he completely filled in by the funeral director, page	edicai (29a. Certifier (Check only one) 1 ☐ Certifying Ph., 2 ☐ Medical Exam	sician. To the best of my know iner: On the basis of examinat and mariner stated.	wiedye, death occurr tion and/or investigat	ed at the time, date and ion, in my opinion, death	place, and due to the on occurred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
-	To the To the Comp	Σ	29b. Sign true and title of certifier	1 1 10-		29c. License number		29d. Date signed (Mor	ith, Day, Year)
•	4		11 hours 1/2		OX	H0060.	361	Sanuary 1	2006
	6		30. Name and address of person who	ompleted cause of death (Item	23a) (Type, Print)	o 51	Battimor		1,000
	Sta	te	31. Date filed (Month, Day, Year)	32. Rajistrar's Signar	ture di	314,601	11/1/01	C,1112 2	1001
	Regist		JAN 0 6 2	006 Jane	A Spen				

Charles Morris	S	Jr. Pleas	se Type or Prir	nţ,in Blad	ck,lnc	jelible Ink	. Ensure	All Copie	s Are	Legible.	
CT		Unpend item# 23	se Type or Prin a, 27.28a-f. pe State of Ma	rMe, g853 aryland /	,3/22/ Depa	rtment of F	lealth and	Mental H	ygien	enn6	00092
		1- State RegistrAmend Item	#29d Per DV			tificate_of			Reg. N		
Physicia	n	Decedent's Name (First, Middle,	n	air.		0		2. Date of E	D	ay Year	3. Time of Death
/Medica		4a. Facility Name (If not institution,		K/3		4b. City, Town, o	or Location of Dea	Janua th	- T	04 2006 c. County of Death	08:25A [™]
Examine	=1	University of Ma		cal Cen	ter	Baltim				n/a	
Funeral		5. Social Security Number		e (In yrs. last t	birthday)	If Under 1 Year Months Days			irth	9. Birtho	place (State or Foreign
Director		Usual Residence of Decedent	N ZUT		Yrs.	9		Decemb	/	a/ + 40	regland
ehow		10a. State 10b. County		10c. City, To	wn or Loc	ation				1	0d. Inside City Limits
e Mar Miled	cto	HARYLAND P	IA	BAL	tim	ORE					1 Yes 2 No
ith th		10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cour	ntry?
s 23s	Funeral Director		11-fon ave	Ever in 11 C	12.14	2/20	23	Const. Van as h	10	WIA	and the discount
fler de	Ē	11. Marital Status 1 Never Married 2 Married	Armed Forces?		I3. V	Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	NO-	14. Race - Americ Black, White,	
ours a	β	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2×No	Specify:			Specify:	American
1215-0036 within 72 hours after deeth with the Maryland ene. then "natural", or items 23a or 28a-1 show he Medical Exarta her must be notified at	Completed	15. Decedent' (Specify only highes	s Education t grade completed)	16	(Give I	ent's Usual Occup	during most of wo	orking	16b.	Kind of Business/In	dustry
within then	шc	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	O NOT use retire	1/1			11/0	
filled 2 hther other ant, and	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Na	me (First, Midd	le, Maide	n Sumame)	
rlan uid be Mentai rked c	ToB	Charles M.	PORRIS SK				LES/iE	Buch	483	55	
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after deeth with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-1 ehoy other traumatic event, the Medical Exama ner must be notified at		19a/Informant's Name/Relationsh	ip (Type, Print)	15	9b. Mailin	g Address (Street	and Number or R	ural Route Num	ber, City	or Town, State, Zip	Code) 41223
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Pages 1		20a. Method of Disposition 1 Burial 2 Cremation		cemel	tery, crem	atory or other pla	C8)	Date	20c. 1	ocation - City or To	own, State
		4 ☐ Donation 5 ☐ Other (Sp. 21. Social re of Funeral Service L.	· · ·	1//		Name and Addre	ess of Facility	06	KA	15 downe	MARYLAND
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		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused	the death. Do	o not ente	or the mode of dyir	ng, such as cardia	c or respiratory		DIC INN	Approximate Interval Between
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/Medical Examiner		resulting in death)		a consequenc							
	-	Sequentially list conditions,	b. Due to for as	a consequens	a offe		 				
wecuted and i-transit	xaminer	Sequentially list conditions, if any, leaving to initious cause. Enter Underlying Cause (Disease or injury that initiated events	c.								
	ш	resulting in death) Last		a consequenc	e of):						
68760, tificate be eg physicien as the burier	lcal		d								
OX 6	/Mec	IF FEMALE:	23c. If yes, outcome	of pregnancy					- 1		- 1
Box leath cer ettendir 1 for use	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)	у			23d. Date of delive Month	ory Day Year
P.O. BOX that the death cert ed by the ettending deteched for use	by Physician/Medical	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown								
S, D	oy P	Part II. Other significant condition	ns contributing to death b	ut not resulting	in the un	derlying cause giv	ven in Part I.	23e. Dio	tobacco	use contribute to th	ne cause of death?
cords, wrequires been sign should be	ted							1	Yes 2	2 □ No 3 □ Prob	ably 4 Unknown
Becon law in has be e 2 sh	Completed							24a. Wa aut	opsy	24b. Were auto	psy findings available impletion of cause of
Vital Relicion: The certificate ha									formed? 2 □ N	death?	2 No
f Vita	o Be	25. Was case referred to medical examiner? 1√XYes 2 □ No	Hospital:	- MACO		a□ po. i Ott	26. Place of De			/	
On of ding Phys	Ë	27. Manner of Death	28a. Date of Inju		Outpatient Time of	3 DOA 28c. Injur	y at	28d. Describe		6 □Other (Specifi	·)
isior ktendin death. ctor: Afr	atlo	1 □ Natural 5 □ Pending 2 □ Accident investig	ation Find $1/4/20$	006 Fnc	1 7:30	AM 1	rk?]Yes 2∭XNo	unk			
Division of Vital Records, for Attending Physician: The law requires the efter death. Director: After this certificate has been signed in by the funeral director, page 2 should be death.	Certification: To	3 ☐ Suicide 6 【☐ Could n 4 ☐ Homicide determi	ned building, et	ury - At home, c. (Specify)	farm, stre	et, factory, office		City or T	own, Sta	nd Number or Rura	Route Number,
9 9 6 6	Ce	29a. Certifier 1 ☐ Certifying	found in					Baltimor	e, MD)	
24 ho 24 ho Fun etely	Medical ((Check only 2 Medical E	g Physicien: To the best Examiner: On the basis of and manner sta	examination a	and/or inv	estigation, in my o	me, date and place opinion, death occ	e, and due to th urred at the time	e cause(: e, date ar	s) and manner as st nd place, and due to	ated. the cause(s)
To the within 2 To the complet	Me	29b. Signature and otle of certifier				29c. Licens	se number		29d. D	ate signed (Month,	
- Nev		> Theofore	U King		2		OCME		Jan		006 <u>.</u> 005
IDYY		30. Name and address of person v	who completed cause of	eath (Item 23a	a) (Type, f		<i>a</i> .				
		31. Date filed (Month, Day, Year)	32 Registr	ar's Signature		III Pe	nn Stree	t Balt	ımor	e, Maryla	nd 21201
Stat Registra		JAN 0.6		- Signature	A	route					
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Page Page			For 1 _ State	State of Maryland				ind M	ental Hyg	jiene (16	00093
Physician (Modical) Description of the property of the proper					Cer	unca	le or Death					
Remarks Compared	Physici	an	1. Decedent's Name (First, Middle, Last)	<i></i>		101	1 / -				Year	
The state Sevent Name Products Sevent Name			Dorothy A			11	ciche		Aninky	1		11.12 8 4
Social Service Number 16 16 16 16 17 18 18 18 18 18 18 18	Examir	ner	7 1/50/	reet and number)	,	4b. City	, Town, or Location of	f Death	/	4c. County	of Death	
218-09-5664 Maryland Harford Bel Air 100 City, Year of Location				ins pospital		106	H. marc					
The control of the				M OKIE	**			Min.	(Month, Day	, Year)	9. Birthp	place (State or Foreign ntry)
The state The	Director		218-09-5664	85	115.				Apr. 19	, 1920	_Mar	yland
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Security Watshirt Contenting (Type, Print) 19st. Informatic Name Relationship (Type, Print) 19st.	Hed Had		17. Father's Name (First, Middle, Last)		Воодо	110		r's Name	(First, Middle,			5
Physician (Medical Examiner) 23a Part I. Errife the bilesces or complexitors that caused the depth. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Oncide in the part is conditions on cause on each line. 23a Part I. Errife the bilesces or complexitors that caused the depth. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a Part I. Errife the bilesces or complexitors that caused the depth of the part of	d be entai	OB	George Washington	Collenberg,	Jr.		Let	itia	Elizal	beth S	mith	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	ding	/Me		o If was outcome of program	201							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	atten for us	lan	ZOD. 1143 GOODGOIL PROGRAM	1 Live birth 2 ☐ Fetal	death 3							-
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Part	The page	S										2 No
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Part	eath.	cati	2 ☐ Accident investigation					No				
Part	r Att	E	determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, facto	y, office	2	81. Location (S. City or Town	treet and Numb n, State)	er or Rura	al Route Number,
Part	is a safe of the control of the cont											
Part	dosp 4 hou rune ely fil	cai	Check only 2 Medical Examin	er: On the basis of examinat	wledge, death	occurred	at the time, date and	d place, a	nd due to the c	ause(s) and ma	nner as s	stated.
Part	tha tha tha tha tha f	led	Unity	and manner stated.								
30 Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Bogistrar 32. Registrar's Signature	To Will	2	29b. Signature and title of certifier						2	9d. Date signe	i (Month,	Day, Year)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year) 32. Registrar's Signature			1 and The	7		R	ES-000			1-4-06		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Bogistrar 32. Registrar's Signature	B		30 Name and address of person who cor	pleled cause of death (Item	23а) (Туре,	Print)	0/ 1	0 '	,	4.4	,	_
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Ronny Antoine	Martin	State of Maryland / Department of Health and Mental Hygiene

ROTHTY		TOINE MARTIN For State Registrar	State of	Maryland /	•	artment <i>rtificate</i>					eg. No.	006	00094
		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
Physic /Medi		RONNY A.	MARTIN							January		2006	21:34 P M
Exami		4a. Facility Name (If not institution,	give street and numb	er)				Location	of Death		4c. C	ounty of Dea	th
		2600 Blk of Marb				Balt:		e If Under	24 Hrs	0 = . (D: 1)		N/A	h-1 (2) - 5
Funeral Director		217-23-5424	Sex 7. XXM 2□F	Age (In yrs. last	Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day FEB. 2	. Year)	l Co	thplace (State or Foreign ountry) ARYLAND
put ≱ :		Usual Residence of Decedent 10a, State 10b, County		10c. City, T	own or Lo	cation							10d. Inside City Limits
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "natural", or Items 23a or 28e-1 show other treumatic event, the Medical Examinar must be untilified at	ō	MARYLAND N/.	Λ.			rimori	Ε	1 ⊠ Ye					1 ⊠ Yes 2 □ No
the A	Funeral Director	10e. Street and Number				10f. Zip			· · · · · · · · · · · · · · · · · · ·	10g. Citizen of What			ountry?
with Ba or	0		DB				212	30			U	U.S.A.	
Jeath The 2:	lera	2805 HINSDALE 11. Marital Status	12. Was Deced		13.	Was Deced			igin? (Sp	? (Specify Yes or No- uerto Rican, etc.)		14. Race - American Indian, Black, White, etc.	
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rat', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date	es:		10 105 4	2121110	эрвспу.				Specify: BL.	ACK
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be fi	Be		131/									,,	
d Men narke	ဥ	PATRICK EVANS 19a. Informant's Name/Relationshi	O (Type Print)		ROBERTA MA 19b. Mailing Address (Street and Number or Rural Route Nu							Town. State.	Zip Code)
d 2 sh h and 7 le m treum						•				timore,			
Healt Healt		Roberta Martin/	Mother	20b. Plac						T			
permit. Pages 1 end 2 Depertment of Health a Important: If Item 27 le eny Injury or other tre once.		0a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation · 3 ☐ Removal from State ARBUTUS MEMORIAL 01-06-06 BALTIMORE,										MARYLAND	
it. Partme		21. Signature of Funeral Services											
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		23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that car	used the death.	Do not en	ter the mod	le of dyin	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a SMOT		NO UL	Jo	0f	H	EAL				Onset and Death
/Medical		resulting in death)	Due to (o	r as a consequer	nce of):								
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death certifi e ettending id for use es	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnanc		¬					2	3d. Date of de	elivery
death cer ettendir d for use	cla	in the past 12 months?	4□Pregna	th 2□Fetal de int at time of deal		⊒Ectopic pr ⊒ Other <i>(sp</i>						Month	Day Year
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law requires seen so should	Completed									24a. Was		24b. Were a	autopsy findings available completion of cause of
The lavate hes	E									perfo	med? 2□ No	death?	_
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ysicl is cer direc	0 8	examiner? 1∑ Yes 2 □ No	Hospital: 1 🗆 In	patient 2 EF	R/Outpatie	nt 3 DC	Oth Oth	er: 4□ N	lursing H	ome 5 Resid	dence 6	i ∭Other (Sp	ecify) Scene
or Attending Physiclan: effer death. Director: After this certific in by the funeral director.	n.	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date o	f fnjury 2 n, <i>Day Year)</i>	8b. Time Injury	of a	28c. Injur Wor	y at k?		28d. Describe I			
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er de	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 28e. Place buildin	of Injury - At homing, etc. (Specify)	e, farm, s	treet, factor	y, office			28f. Location (S City or Tox	Street and vn, State)	d Number or F	Rural Route Number,
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Hospi 4 hou Fune fely fill	edical	29a. Certifier 1 Certifyin (Check only one) Medical I	Physician: To the examiner: On the ba and mann	sis of examinatio	edge, dea on and/or i	th occurred nvestigation	at the til	me, date a pinion, de	ath occur	, and due to the rred at the time,	cause(s) date and	and manner a place, and du	as stated. ue to the cause(s)
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		1 aust	2 '			0.	.C.M	.E.			Janua	ary 02,	, 2006
^		30. Name and address of person	who completed cause	e of death (Item 2	23a) (Type	, Print)		-					
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State Registrar

31. Date filed (Month, Day, Year)

			1 - For State Registrar		of Marylar		artmen tificat					Reg. No.	006	0009	95
	Physicia	an	Decedent's Name (First, Middle	. ,	Eversol	e McMal	2012				2. Date of De Month	Day	Yea		Death
	/Medic	al	4a. Facility Name (If not institution			e nena		Tour or	Location of	of Dooth	Januar		2006 County of De	1728	M
	Examin	er	5305 Waneta Ro		mber)			hesd		JI Death		i	ontgom		
*5,	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Bir	th	9. B	irthplace (State or	Foreign
	Director		223-86-7370	1 ☐ M 21X F	51	Yrs.	Months	Days	Hours	Min.	(Month, Da Aug. 1	19	. (ountry) Irginia	
	D.		Usual Residence of Decedent		10- 0	. T									
	ehov ehov	7	10a. State 10b. County Maryland Montgo		10c. Ci	ty, Town or Lo								10d. Inside City	
	the M	Directo	10e. Street and Number	omery		Beth	10f. Zip	Code			· · · · · · · · · · · · · · · · · · ·	100 Citis	en of Whal		
	with Sa or		5305 Waneta Roa	ad			101. 219		816				ted St	•	
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۵	after or item		1 Never Married 2 Marri	ed 1 ☐ Yes	2 🔀 No						Rican, etc.)		Black, Wi		
9500-61212	i within 72 hours after death with the Maryland jiene. Jiene. Than "natural", or itema 23e or 28e-f ehow Inte Macical Examiner must be notified at	d by	3 Widowed 4 Divorced	If Yes, Gi Year or D	ates:		1 🗌 Yes	ZKUNO	Specify:				Specify:	White	
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	하는 수 를 다	e Co	17. Father's Name (First, Middle, I					-	18. Mothe	er's Name	(First, Middle,	Maiden .	Sumame)		-
Maryiand	e d la be	ToB	Clark Eversole						Ki	m Co	1eman				
Mar	is 1 and 2 should of Health and Mer Item 27 Is marke other traumatic	15	19a. Informant's Name/Relationsh Anthony J. McMa		ınd		-				al Route Numbe sda, Ma				
ē,	s 1 ar if Hea Item		20a. Method of Disposition	_	20b.	Place of Dispo	sition (Nan	ne of		0	ate			or Town, State	
Ë			1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S _t		State St	cemetery, crer • Paul urch Ce	S	r37	″ ¦J	anua 200	ry 5,	Hagu	e, Vi	ginia	
Baltimore,	permit. Page Department (Important: If any injury or once.		21. Signature of Funeral Servi A l	icensee	м00	100 RC	Name an	AAddres A. P	s of Facility umphi	rey 1	Funeral Bethesd	Home	e/ C1	esda-Chernase, Inc	vy •
	Dhuaiaian		23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	caused the dea each line. astatic	th. Do not ent	er the mod	e of dying					2001	Approximate Interval Betwo	eath
	Physician /Medical		disease or condition resulting in death)	a	(or as a conse		. Cam	CEI						2 years	
	Examiner		Sequentially list conditions	b											
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28	ficate g phys	edic		0											
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ם ה	ding Ph h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date (Mor	of Injury th, Day Year)	28b. Time of	2	8c. Injury Work	at ?	2	28d. Describe I	now injury	occurred		
<u>0</u>	Vttendii death. ctor: A y the fu	cati	2 Accident investig	ation			М		'es 2 □ 1						
Division	spital or Attenc ours after death neral Director: filled in by the	Certification:	4 Homicide determi	ned 286. Place	e of Injury - At h ing, etc. (Speci	ome, farm, str fy)	eel, factory	r, office		4	28f. Location (5 City or Tov	Street and vn, State)	Number or i	Rural Route Numbe	⊖ <i>r</i> ,
	To the Hospital or Attending Physician: within 24 hours after death: To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier 1 ☐ Certifyin (Check only one)	g Physician: To the Examiner: On the b	e best of my know easis of examina oner stated.	owledge, deatl ation and/or in	occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) a date and	and manner place, and di	as stated. ue to the cause(s)	
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	`		,	6/1				D00	3329	3		Janu	ary 3,	2006	
	10		30. Name and address of person of Frederick P. Sm:					enite	#130	00 C	hevy Ch	266	Marsil (and 20815	
E	Sta	te	31. Date filed (Month, Day, Year)		Regiserar's Sign			CIIGO	. ,, ± 3 (,	7 011	وعوري	y 1 c		
	Registr			6 2006	NOV		Local	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Amend Item # 4a&25 Per PHY G859 rtifig 8 to 16 Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** gelina armary 2 2:00 2006 /Medical 4a 6401 Name (If not institution, give street and number) 4b. City. Town, of Location of Death 4c. County of Death Examiner altimore Va Loch Raven 540 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 1,1930 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 ☐ M 2 😿 F 75 Yrs Director **Philippines** 216-62-3456 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State ral', or Items 23s or 28a-f show Evan ther must be notified at 1 X Yes 2 ☐ No Director Maryland | Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6401 Loch Raven Blvd. Apt 540 21239 U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. sm 27 is marked other than "natural", or Itel 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Philipino 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk 4+ Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bonifacio Martinez Trinidad Villanueva 2 19a. Informant's Name/Relationship (Type, Print) (Nephew) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra <u>QRG8</u>. Eduardo Martinez Canilang 4712 Rams Horn Row Ellicott City, Maryland 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 1-5-2006 Catonsville, Maryland 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, Maryland 21045 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause — each lin — Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): Box 68760 Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year for Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nevension 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an I has autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical exampler? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 (ds 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Sea this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation after death. 1 🗌 Yes 2 🗆 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ö within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies w BG0059855 2006

Registrar
DHMH 17 Rev 1/2001

State

(Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

129:120

ock

JAN 0 6 2006

31. Date filed (Month, Day, Year)

Baltimore pita Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 28, 1 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1□M 2XF Months Min Yrs. 54 Director 154-44-3606 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Director MD Baltimore Parkton Canthia 10e. Street and Number 10f. Zip Code 17008 Sunswept Lane 21120 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) McCullough 4 Analysist or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth eny jury or other traumatic event soice. 17. Father's Name (First, Middle, Last) Be ပ Raymond McCullough Irene Davey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17008 Sunswept Lane Parkton, MD 21120 Robert H. Niebuhr/Husband Jan. 3,2006 20b. Place of Disposition (Name of 20a. Method of Disposition Metro Crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral S ael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** breast /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 2 Yes 2 1 No 3 Ectopic pregnancy detached for 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinai

32 Registrar's Signature

MI

5 Pending investigation

6 Could not be determined

McCullough

1 - State Registrar

Cynthia

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Ann

4a. Facility Name (If not institution, give, street and number)

Amend item#20b, perlyh, G851, 1-3-06 Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

10g. Citizen of What Country? USA 14. Race - American Indian. Black, White, etc. Specify: White 16b. Kind of Business/Industry Social Security 18. Mother's Name (First, Middle, Maiden Sumame) 20c. Location - City or Town, State Baltimore, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Road Timonium, MD 21093 Approximate Interval Between Onset and Death years 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 Yes 2□ No 2 💢 No 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 19027 January 1, 2006 Baltimore 240/ W Belvedere Ave Bultimore MPZ1215

Reg. No.

3. Time of Death

11:32

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2X No

NJ

Year

2006

4c. County of Death

1951

2. Date of Death

anuan

Month

certificate

: After this certification and funeral director.

Division of Vital

To the Hospital or Attending Physician:

death.

Director: mpletely filled in by the

within 24 hours after To the Funeral Dire

State Registrar

δ

Completed

2

Certification;

25. Was case referred to medical examiner?

29b. Signature and title of certifier

Huang 31. Date filed (Month, Day, Year)

JAN 0 3 2006

1 ☐ Yes 2 💢 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 | Homicide

1 X Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital

28b. Time of

28c. Injury at Work?

29c. License number

PAS

1 ☐ Yes 2 ☐ No

CPM 06-00108 Bruce Marshall

			For State Registrar	State of Maryland /		rtment of He		Mental Hygie	2000	00098
	Physici	20	Decedent's Name (First, Middle, Last,)				2. Date of Death	Day Year	3. Time of Death
	/Medic		Bruce Jero		all			January	04, 2006	15:05 M
1	Examir	er	4a. Facility Name (If not institution, give 36 Shrewsbury Cour	rt			ry Hall		4c. County of Death Baltin	nore
	Funeral Director		5. Social Security Number 6. Sec. 215 - 56 - 4815	7. Age (In yrs. last bi	irthday)_ Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar)	place (State or Foreign ntry)
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Loc	ation				10d. Inside City Limits
	Maryl	to	MD Baltin	Po-	T1 1	1104				1 ☐ Yes 2 ☑ No
	with the Maryland a or 28s-f show be routiled at	Funeral Director	10e. Street and Number	TORE TEN	.4	10f. Zip Code		10g.	Citizen of What Cou	ntry?
	death wi	raiD	36 Shrewsby	ry Court		SEIR	3		USA	
	item item	une	The state of the s	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
5-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artiment of Heelth and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23a or 28s-1 show ortant: if item 27 is marked other than "natural", or items 23a or 28s-1 show injury or other traumatic event, the Medical Evantinal must be rediffed at injury or other traumatic.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	☐ Yes 275-No	Specify:		Specify:	nite
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad			ent's Usual Occupa		ina 16b	. Kind of Business/Ir	ndustry
2121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired)		k	4.4.1/	
	Hygir other	Be Co	17. Father's Name (First, Middle, Last)		Jert	wer	18. Mother's Nam	e (First, Middle, Maid	den Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. Ie marked other than aumatic event, the Ms	To B	Roland S. M	Roshall JR			Helen	Mica	5	
lar)	2 sho		19a. Informant's Name/Relationship (Ty	pe, Print) 19	b. Mailing	Address (Street a	nd Number or Ru	al Route Number, Ci	ty or Town, State, Zij	Code)
	of Heelth of Heelth litem 27		20a. Method of Disposition		4/S	HVONCIC!	e Road	PERKVITE Date 200	May Cod Location - City or T	2/234
Baltimore,	ages ant of it: if it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	comete	ary, crem	atory or other place	9)			
altir	permit. Pages Department of Important: If I eny injury or o		21. Signature of Funeral Service Licens	90 6 10		od Cemeto Name and Address	s o Facility	9,2006 He	RKVILLE I	NICKULLINI
ä	Depar Impo		Kimberly ld.	Sackstky	8	800 Hace	Ford Roc			1and 21234
			23a. Part1. Enter the disease, or compf shock, or heart failure. List only of	dations that caused the death. Do	not ente	r the mode of dying	, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Artenoxlen	fic	(goles)	regalen	- Disea	16	Onset and Death
	Examiner			Due to (or as a consequence	of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter I Inderlying	Due to (or as a consequence	of):					
K	acuted ind transi	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
8760,	cate be executed physicien and the burial-transit		rossing in asam, cast	Due to (or as a consequence	or):					
687	ificate g physi as the l	edical		J						
Вох	death certifi e attending id for use as	M/UE	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	h 3 🗆	Ectopic pregnancy			23d. Date of deliv	ery
P.O. E	that the death certificed by the attending of detached for use as	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant at time of death 9☐ Unknown		Other (specify)			Month	Day Year
	The law requires that the set has been signed by this sage 2 should be detached.	y Ph	Part II. Other significant conditions cor	ntributing to death but not resulting	in the und	derlying cause give	n in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
ords	w requires that been signed b should be deta	ted t	Pirhetes he	flotus				1 ☐ Yes	20 No 3 □ Prot	pably 4 ∐Unknown
of Vital Records,	alawr nasbe e 2 sh	Completed by						24a. Was an autopsy	24b. Were auto prior to co	opsy findings available mpletion of cause of
a F	n: The		_					Performed Yes 2□		2 □ No
₹	Physician: The lav this certificete has ral director, page 2	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	lospital:	utnatient	3 □ DOA Other	*	h <i>Check only</i> one) ome 5 ☐ Residence	6 ETOther (Creek	til game
J Of	ng Phy ter this	T: T	27. Manner of Death	28a. Date of Injury 28b.	Time of Injury	28c. Injury Work		28d. Describe how in		SCENE
Sior	eath. or: Af the fur	catic	2 ☐ Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			es 2 □No			
Division	or Att	ertifi	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, stre	et, factory, office		28f. Location (Street City or Town, St	and Number or Rura ate)	Il Route Number,
	spital	Medical Certification:	29a Certifier 1 Certifying Phys	sician: To the best of my knowledg	e, death	conumed at the time	a, data and place,	and dua to the cause	e(s) and manner as s	tatad.
	he Ho in 24 t he Fu pletely	edic	(Check only 2) Medical Examinations	ner: On the basis of examination are and manner stated.	nd/or inve	estigation, in my opi	inion, death occur	red at the time, date	and place, and due to	the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Σ	29b. Signature and tylle of certifier			29c. License			Date signed (Month,	
	λ	1	1 Correct	NU			C.M.E.	J	lanuary 05	, 2006
	4		30. Name and address of person who co	empleted cause of death (Item 23a)			t. Balti	nore, Mary	rland 2120	1
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature			- , <i>DELLE</i>	, riary	- Land 2120	L
3	Registr	ar	JAN 0 6 2006	Allegran All A	Jacob	2)				

			1 - For State Registrar	State of Marylan	d / Depa		lealth and	Mental Hyg		006	nnn	99
	Physici	an	Decedent's Name (First, Middle, L	AAA.		imodio or i	<i></i>	2. Date of Dea Month Januar	ith Day	2006	3. Time of 1	Death M
	/Medic Examir Funeral Director			ive street and number) 9 pi fal Cente Sex 7. Age (In yrs.)	last birthday) Yrs.	4b. City, Town, or UPS If Under 1 Year Months Days	Location of Dea	ath S. 8. Date of Birth	4c. C	9. Birth	11	
	ס	'n	Usual Residence of Decedent 10a. State 10b. County Md Carrol	10c. City	y, Town or Lo SVille			riai cii 1	0 19	10 11	10d. Inside Cit	•
	with the N 3e or 28e-f	Funeral Director	10e. Street and Number 7200 Third Avent	ie		10f. Zip Code 21784			10g. Citize	en of What Cou	25	
936	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "neturel", or Items 23e or 28e-f show event, the Medical Evarifner risat by Indiffical at		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	43-	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (In, Mexican, Pue Specify:	(Specify Yes or No- orto Rican, etc.)		A. Race - Amer Black, White Specify: whi	, etc.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or items 23e or 28e-1 show amy injury or other treumatic event, the Medical Examinating the nutities at ance.	Completed by	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)	Education	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	during most of w	rorking		of Business/I		
yland	outd be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, La. Henry E. Magnus					ame (First, Middle, ine Munch		'umame)		
, Mar	and 2 sho ealth and m 27 le mu her treumu		John Magnusen (so	on)	2362	Braddock	Rd., M	t. Airy,	Md 2	1771		
Baltimore,	it. Pages 1 rtment of H rtent: If ite njury or oti		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Service Lice)	city) Nas	ssau K	osition (Name of matory or other place nolls Cem	. 1-9		Port		igton, N	
Ba	permi Depa Impo any ii		Parge Hargh 23a. Part 1. Enter the disease, or co	t ofenbert		P.O. Box	195 Syk	aight Fun esville,	Md 2:		Approximate	
760,	icate be executed /Medical bhysician and street from the burial fransit sthe burial fransit	dical Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Ener Undortying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):	iscular	Λ	191			Interval Betw Onset and D	veen
.O. Box 68	death certii e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do	Ideath 3	⊒Ectopic pregnancy □ Other (specify)			23	d. Date of deliving		'ear
S, D	= 0 7	by	Part II. Other significant conditions	s contributing to death but not rest	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	_		the cause of de	
of Vital Record		Completed							med? 2 No	24b. Were aut prior to co death? 1 ☐ Yes	opsy findings a ompletion of ca	vailable use of
of Vit	S S	To Be	25. Was case referred to medical examiner? 1 Yes 2 Ao 27. Manner of Death		ER/Outpatier		er: 4 🗆 Nursing	eath (Check only or Home 5 ☐ Resid	ence 6 (ify)	
Division	ittending death. stor: After / the fune	Certification:	1 Mainter of Death 1 Matural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 380 Blood of Injury At he	Injury ome, farm, st	M 1 🗀	yai ⟨? Yes 2 □ No	28d. Describe he	treet and		ral Route Numb)er,
ō	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by	ledical Cer	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of my kno aminer: On the basis of examina	wledge, deat	h occurred at the tin	ne, date and pla	ce, and due to the c	ause(s) a	nd manner as	stated.	
)	To the h within 24 To the F complete	Medi	29b. Signature and title of certifier	and manner stated.		29c. License				signed (Month)		
	17		30. Name and address of person	o completed cause of death (Item	1 23a) (Type, AUP			mingter	M	0 21	157	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	erut	Carll	VV 1 7 1		/			

DHMH 17 Rev 1/2001

ORIGINAL

McElory, James C Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Unipend 11em#1,23a,27,pen#E,651,1/23/06 IT State of Maryland / Department of Health and Mental Hygiene 06-00095 CT00100 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** James Clinton McElroy, Jr. 10:40 P^M 03 2006 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Westminster Carrol1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 12, 1966 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1√2 M 2□ F Yrs. 39 219-96-0213 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Carrol1 Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21048 USA 2239 Deer Park Road Funeral fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐XNo Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) Product Manager Building Supply . Pages 1 and 2 should be filed viment of Health and Mental Hygie tent: if Item 27 is marked other toury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Clinton McElroy, Sr. Helen Marie Yingling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dawn McElroy (Wife) 2239 Deer Park Road Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any Injury or once. Lake View Mem. Park 1/7/2006 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)
Sykesville, MD 21784 (410)-795-1400 Blian Hailt di. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Hypertensive Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner inding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetet death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No atten for u 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 Other (specify) ete has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 🗆 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2℃ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To XXYes 2 No To the Hospitel or Attending Ph within 24 hours after death. To the Funaral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201 32. Refistrar's Signature

31. Date filed (Month, Day, Year)

OCME

January 4,

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year mes JANUARYO 3 4:45 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner AGNES KOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 249-44-545 1 M 2 □ F 5,1928 South Yrs. Director arolina Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland timore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 820 Ave 51 Pages 1 and 2 should be filed within 72 hours after death vient of Health and Mental Hygiene. nent of Health and Mental Hygiene. int: If Hem 27 ie marked other than "naturel", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 MYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Velder OX treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code),
700 New Hampshire Ave. N.W. Unit 5/2 Washington, DC 19a. Informant's Name/Relationship (Type, Print) (dauster) Allen Hampshire Marcus s. Shirley Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Dep. rtment of H
Important: If Ite
any njury or ot
once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Son torest 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility
JOSEPH L. RUS
2222 W. NOrth Avei W.North 23a. Part / Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS UNKNOWN /Medical Due to (or as a consequence of): Examiner REGILT GANZ RENE Esquentially list sonditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events UN KINDOON Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of). Completed by Physician/Medical the attending pl JE FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death signed by the at d be detached for 5 Other (specify) 1 ☐ Yes 12 ☐ No o. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 No STAGE RENAU DISEBSE 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DIABETES MELL (TUS 24a. Was an page 2 hes autopsy performed certificete CEREBROVALCULAR STROKE 2 1No of Vital 1 Yes Physicien: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: ဥ 1 Yes 2 No Impatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? Certification: 28b. Time of 28d. Describe how injury occurred After Division To the Hospitel or Attending 5 Pending investigation 1-Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death within 24 hours after de To the Funerel Directo completely filled in by th 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M-D Svery 19515 JANUARY 03 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRICEYURICUMAR BUCH 00p S. CATON AVE BALTIMORE MD 21229

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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South

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day William Herbert Moore, Jr. Jan. 2:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan 25, 19 9. Birthplace (State or Foreign Country) Mary Land Funeral Days Hours 219-10-8272 10 M 20 F Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other then "natural", or items 23e or 28e-f ehow treumatic event, the Medical Examinar must be routified at Maryland Director Carroll Manchester 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3408 Warehime Rd. U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
1f Yes 6Ne 5 1 946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Supervisor Paper Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Heelth and Mental William H. Moore, Sr. Lillian Elizabeth Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3408 Warehime Rd. Manchester, Md. 21102 Barbara Bray - daughter f Heelth other 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. Date 20a. Method of Disposition Pages 1 ment of 8 tant: If it 6 1 Burial 2 Cremation 3 □Removal from State permit. Page Department of Important: If eny injury or once. Dulaney Valley Mem. Timonium. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ecknowing The Parall 3296 Charmil Dr. Chapel P.A. ASL ROBER Manchester, Md. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Intra-asdominal **Physician** 40015 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of leah?

1 Yes 2□ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death |Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0044362 30. Name and address of person who completed cause o ath (Item 23a) (Type, Print) ENRICO A. GIANGERUSO. MD 200 MEMORIAL AVE WESTMINSTER MD 2115 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 05 2008 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Year 12:24 PM **Physician** MULLER, JR. JANUARY 1, CHARLES 2006 /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Hours Funeral 1**∑** M 2□ F 75 220-26-5616 4/21/1930 MARYLAND Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No TANEYTOWN Directo CARROLL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21787 10 MILL AVE. filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bfack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Year or Dates: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) parmit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiens Important: If Item 27 is marked other than "na any injury or other traumatic event, the Madic once. Elementary/Secondary (0-12) College (1-4or 5+) AGRICULTURE FARMER 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LULA EDNA YINGLING CHARLES MULLER, SR. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 MILL AVE., TANEYTOWN, MD BONNIE YINGLING -DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1

Burial 2

Defemation 3 □ Removal from State SALEM CHURCH CEM. 1/5/06 WESTMINSTER, MD. 4 Donation 5 Donation (Specify) Sign Pure Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ISCHEMIC CARDIOMYOPATHY Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit certificate be executad CORONARY ARTERY DISEASE physician and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical d. as the attending IF FEMALE: USB 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ivision of Vital Records, þ should be 1 Yes 2 No 3 Probably 4 Unknown RESPIRATORY FAILURE Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETES autopsy certificete has 1 ☐ Yes 2 ☐ No 2**X** No LACTIC ACIDOSIS After this certification funeral director. or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28c. Injury at Work? Date of fnjury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours e To the Funeral I completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1-1-06 mit NOUN D 31826 الح م 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 LINTHICUM. M. D. . RICHARD jistrar's Signature 31. Date filed (Month Aav Year) 5 State 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** CHARLES MYERS, JR January 1, 8:22 p M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner **Baltimore EDENWALD** Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1∰ M 2□ F 98 Vrs Director 216-05-2405 November 14,1907 Maryland Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a State 10b. County 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 21286 800 Southerly Road IISA Items 23e by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural" ~ "- any injury or other treumatic even." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X XXo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2**X** XX Specify: White 3 XiXvidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate 6 Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Myers Sr Catherine Phillip 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas C Vogt Nephew 806 Sharon Circle West Chester Pennsylvania 19382 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Dulaney Valley Mem Gardens 1/6/06 Timonium, Maryland 4/□ Donation 5 □ Other (Specify) 22. Name and Address of Facility MITCHOIL-WIEDEFELT FUNEYAL HOME INC ignature of Funeral Serv 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONCINSTUM MUNTA disease or condition resulting in death) 110mi /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the burial Box 68760. Physician/Medical IF FEMALE . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 page 2 should be 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 21 NO 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 42 ursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his funeral 28c. Injury at Work? 27. Manger of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospitel or Attending PI
 A hours after death.
 Funerel Director: After the Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funerel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 To the the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) ္က 127838 127838 JANUANY 3 2006

9ath (Item 23a) (Type, Print) 121091

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Registrar DHMH 17 Rev 1/200

State

30. Nam and address of person who completed cause of death (Item 23a) (Type, Print)

7.0

2. Registrar's Signature

JOHN SHAVINS

JAN 0 4 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 26 per doc 9851 1-20-06 vt. State of Maryland / Department of Health and Mental Hygiene () () () For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year January 1, Grace Elizabeth Heinz Mayes 2006 10:01 a[™] 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 12320 Rosslare Ridge Rd. Unit 101 Timonium Baltimore | I Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 3,1920 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Months 1 ☐ M 2 ☐ F Yrs. 214-14-5776 85 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093-8216 12320 Rosslare Ridge Rd. Unit 101 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 ¥ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Administrator Telephone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clinton Ε. Heinz Grace Μ. Lauterbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Chamberlain / Cousin 2708 Alden Road Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 NOth Specify Enton ment Dulaney Valley Mauso, 1/5/06 Timonium, Maryland 21. Signature of Fundal Service Linesee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the disease or complice shock, or heart failure. List only on ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, scause on each line. Approximate Interval Between Onset and Death or complic Immediate Cause (Final disease or condition resulting in death) OV an Due to (or as consequence of): 2 her Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other:_ 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Hursing Home 5 Aesidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Maryland 21215-0036 or other traumatic event, Pages 1 and 2 should be nent of Health and Mental it of Health a: Baltimore, Department of Important: If any injury or another. **Physician** /Medical Examiner igned by the attending physician and be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, cete has been signification of page 2 should b certificete has Hospitel or Attending Physicien: funeral director After within 24 hours after death. To the Funerel Director: A the filled in by completely To the I

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al Hygiene.

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within 72 hours after death

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of contrier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FamilyCare Associates at GBMC 6565 N. Charles Street, Suite 613 Baltimore, MD. 21204

29d. Date signed (Month, Day, Year)

90

29c. License number

0005691

ORIGINAL

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			Registrar 1. Decedent's Name (First, Middle, Last)				tineate of t	Jean		2. Date of D	Reg. No. eath			3. Time of Death
	Physicia		FRANCES MA	LCZEWSK	т					Month JANUARY	Day 7		Year 006	8:15 A. M.
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location		311101111		County o		0.13 A
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	Funeral		5. Social Security Number 6. Sec	M 2 X F 7.	Age (In yrs.	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of B	av. Yearl		Coun	
	Director		053-20-8519 Usual Residence of Decedent		99	115.		1		Oct. 3	, 19	06 1	New 1	rork
	yland now		10a. State 10b. County		10c. City	, Town or Lo	cation						1	Od. Inside City Limits
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	item Item Iner	Funerai Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deced Armed Ford 1 ☐ Yes 2	es?	S. 13. 1	Was Decedent of Hi f Yes, specify Cuba	ispanic Or in, Mexicai	n, Puerto	Rican, etc.)	0-		, White,	an Indian, etc.
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. So other than "natural", or items 23s or 28s-1 show event, the Medical Examiner must be notified at		3 XWidowed 4 □ Divorced	If Yes, Give Year or Dat			1□Yes 🛣 No	Specify:				Specify:	Ţ	√hite
20	72 ho natura	Completed by	15. Decedent's Edu (Specify only highest grad			16a. Dece	dent's Usual Occupa	ation	t of work	ina	16b. Ki	nd of Bus	iness/Ind	lustry
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	e filed within at Hygiene. I other than '	e Co	17. Father's Name (First, Middle, Last)			Ter	ephone Cl		er's Name	(First, Middle				tility
Maryland	d be ental ked o	To Be	Joseph (nmn)	Golu	sinski				nerir	•	(nmn			ncelska
ary	2 should be and Mental la marked of raumatic ev	۲	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	ng Address (Street a	and Numb	er or Rura	al Route Numi	ber, City o	r Town, S	itate, Zip	Code)
	and 2 alth a 127 ls		Barbara Johann - D	aughter		773 H	enderson	Road	, Bel	L Air,	Mary.	land	210	14
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If tiem 27 Ia marked any injury or other traumatic en 90cg.		20a. Method of Disposition 1 Burial 2 □ Cremation 3	lemoval from St		lace of Dispo emetery, crei	sition (Name of matory or other plac	(e)		Date	20c. Lo	cation - C	City or To	wn, State
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			shock, or heart failure. List only of Immediate Cause (Final	ne cause on ear	ch line.	00 1101 0111								Interval Between Onset and Death
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	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to /o	r as a conseq	uance of):						_	_	
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Вох	death certifi e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outco	ome of pregna th 2 Feta	incy	Ectopic pregnancy	,				23d. Date	of delive	ry
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of d		Other (specify)					Mont	th	Day Year
P.0	requires that the de een signed by the a hould be detached to	Phy	9 Unknown			. National to About		an in Bank		22a Did	tohoooo	oo contril	huto to th	e cause of death?
ŝ	ires tha signed d be de	by	Part II. Other significant conditions co	itributing to dea	un but not res	uiting in the u	ndenying cause give	en in Part	ı.		Yes 2		3 ☐ Prob	X
Records,	w requii been s should	Completed								24a. Wa			lore auto	osy findings available
Rec	The law rate has be page 2 sh	duo								auto	opsy formed?	pr	or to cor	npletion of cause of
Vital		e Cc	25. Was case referred to medical					26 Place	e of Deatl	1 ☐ Yes	2 No	11	Yes	2 No
>	Physician: this certific ral director,	OB	examiner?	fospital:	patient 2	ER/Outpatier	nt 3 DOA Oth	\		me 5 Res		6 Other	r (Specify	()
n of		Ju: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time o Injury	f 28c. Injun Worl		-	28d. Describe				
Siol	Attending r death. ector: Afler by the fune	catic	2 Accident investigation				M 1 🗆	Yes 2						_
Division	l or Attenc after death Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place o building	of Injury - At ho g, etc. (Specif	ome, farm, sti y)	reet, factory, office				(Street an own, State		r or Rura	l Route Number,
ш	pital		29a. Certifier 1 Certifying Phy	sician: To the h	est of my kno	wledge deat	h occurred at the tin	ne date a	nd place	and due to the	cause(s)	and man	ner as si	ated
	e Hos 24 h e Fun letely	edical	(Check only 2 Medical Exami		sis of examina									
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in b	Me	29b. Signature and title of certifier				29c. Licens	e number			29d. Dat	e signed	(Month,	Day, Year)
	,		Davil <	2			23	22	55		Jew	U+(12	2006
	5		30. Name and address of person who co								0			
	0		DR. DAVID DUNN - 6 31. Date filed (Month, Day, Year)		IACPHAT ¶strar's Signa) - BEL A	IR, M	D 21	014				
	Sta Registi		4.0.4	006	ASSECTION OF THE PROPERTY OF T	Jr. A	Cart !							
	The second second	*	V L		P. Chiam	10	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Y*e*ar 2:50PM **Physician** 19 211 2006 January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner aboth timore Ursing N/A Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 31,1915 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 1 M 2 F **Funeral** Months Days Min Yrs Maryland 215-14-4966 90 Aug. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, Ira Medical Examinal must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 Yes 2 No Director Maryland N/ABaltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 U.S.A. 1530 Covington Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) U.S. Government Property Administrator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Catherine A. Lanehart 2 Joseph A. Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4137 Doris Avenue, Baltimore, Maryland 21225 Jack E. Neill (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy\Cross Cemetery 01-05-06 Baltimore, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A 130 East Fort Avenue, Baltimore, Maruyland 21230 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician andlomyo 120 1-ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HARRITH 1110 wom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) the the 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by e 5 1 Yes 2 No 3 Probably 4 Whknown peeu ema 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2na 2 No +01 1 Yes 2VNo 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Wursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Certification: Natural 2 Accident 5 Pending death. 1 Yes 2 No investigation within 24 hours after death To the Funeral Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier anucwy eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com-Baltmore and 31. Date filed (Month, Day, Year) tveniu 6N2011 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental H	Hygiene () () 6	nall	0
Certificate of Death		Total No.	

			1 - For State Registrar	State of Marylan		ertificate of		_	ene 0 0 6	00108	
	I		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death	
	Physici /Medio		S	teven Joseph O	ffenb	acher		January	01 Year 200	6 4:35 P ^M	
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	th	
			Howard County G		L	Colum		Howard			
	Funeral Director		217.00.0270	7. Age (In yrs.	last birthday 15 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		thplace (State or Foreign buntry) /ashington, D.C	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or I	ocation		,		10d. Inside City Limits	
	Maryl a-f eho	tor		loward	,,		Ellicott City		1 ☐ Yes 2 No		
	h the	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?	
	th wil	<u>a</u>	8624 Stonehouse Driv	/e			21043		U	.S.A.	
õ	72 hours after death with the Maryland "natural", or Itema 23e or 28e-f ehow colcal Examilier must be notified at	/ Funeral	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give	S. 13	. Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 ☑ No	dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	te, etc.	
2-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:					Зреспу.	White	
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N	filed w Hygier Sther th	ပ္ပ		4+	<u></u>	softw	are engineer				
and	ed fa	Be	17. Father's Name (First, Middle, Last				18. Mother's Nam	e (First, Middle, Ma			
Ž	should nd Men marke	ဥ		ncis Offenbacher				<u>.</u>	Ann Thompso		
	d 2 should th and Mer 7 le marke traumatic		19a. Informant's Name/Relationship (19b. Mai				City or Town, State,	Zip Code)	
e,	C = 01 F		Ms. Laura Offenback 20a. Method of Disposition		lace of Disr	8624 Stonen position (Name of	-	licott City, Ma	ryland 21043 c. Location - City or	Town State	
D E	Pages 1 ar nent of Hea int: If item iry or othe		1 ⊠Burial 2 □ Cremation 3 □	Removal from State	emetery, cri	ematory or other pla	ce)				
	교육원급 .		4 □ Donation 5 □ Other (Special Service Lice)			wn Memorial	Gardens	/09/2006	Marriottsv	sville, Maryland	
מ	Depa Depa Impo eny L		21. Signature of Funetal Service Lice	link tid 11101	293	22. Name and Addre Slack	Funeral Hom				
			23a. Part1. Enter the disease, or com	nlications that caused the death	Do not er	3871	Old Columbia	Pike Ellicott (City, MD 2104	3 Approximate	
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	i. Boriot di	ner the mode or dyn	ig, such as caldiac	or respiratory arrest	•	Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. HYPERTENSIVE	ATH	EROSCIER	OTIC CAR	LDIOVASCU	LAR		
	Examiner			Due to (or as a consequ	uence of):			DISE	324		
7	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	uence of):						
_	icate be executed physician and s the burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):						
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200	certificate Iding phys	edicai		d							
O. Box	requires that the death certific neen signed by the attending p hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	☐Ectopic pregnancy	/		23d. Date of del Month	ivery Day Year	
ī.	thet ed by deta		Part II. Other significant conditions	ontributing to death but not resu	ulting in the	underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?	
cords,	w requires been sign should be	ted by					-	1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Qunknown	
Ľ	rsician: The law is certificate has builtector, page 2 st	Completed						24a. Was an autopsy performe	d? death?	topsy findings available completion of cause of	
VII	tifica tor, p	a	25. Was case referred to medical				26. Place of Deat	1) Syes 2 C	No 1 Yes	2□ No	
	Physician: this certific ral director,	To B	examiner? 1 □XYes 2 □ No	Hospital: 1 ☐ Inpatient 2 🕅	ER/Outpatie	ent 3 DOA Oth	AC.	10	e 6 Other /Sne	cifv)	
25. Was case referred to medical examiner? 1									-1/		

To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun

1 ☐ Yes 2 ☐ No investigation Z Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

29a. Certifier (Check only one)

Medical Certificat

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

January 02, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

ANA
31. Date filed (Month, Day, Year) State

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Registrar

		For State Registrar		State	of Ma	arylan				lealth and Death	Men		gierre Reg. No.	00	6	00109
Physicia /Medic		Decedent's Name A	e <i>(First, Middl</i> e 1tamont	, Last) Pinnoc	k						1	Date of Dea Month	43	, 20	ĎĽ	3. Time of Death 3:50 A M
Examin		4a. Facility Name (/	f not institution	give street and r	number)			4b. Cit	, Town, or	Location of Dea	ath				of Death	
	\$00 A7	Doctors Co		Hospital 6. Sex	7.4-	- //	14 E -4E -4-		ham er 1 Year	If Under 24 Hr	re 0 r	D-44 D:41		ince	Georg	
Funeral Director		125-24-9438	umber	1∭ M 2□ F		89	last birthday Yrs.	Months		Hours Min	n. (Date of Birtl (Month, Day ptember		1916	9. Birthi Coul	
10		Usual Residence of	Decedent							l	Joe	prembei	,,	1310	Janie	itea
nylan ihow		10a. State	10b. County				y, Town or L	ocation								10d. Inside City Limits
Ba-f a	Director	MD	Prince (Ceorges		Be1	tsville									1 X Yes 2 ☐ No
or 2	Dire	10e. Street and Nur	mber					10f. Z	ip Code						Vhat Cou	ntry?
e 23e	Frai	11701 Hear	twood Dr			Constant I	0 10	111 D	20705		10 1	V		.S.A		
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2 hou			15. Decedent	's Education			16a. Dece	dent's Us	ual Occupa	ation			16b. Kir	nd of Bu	siness/ln	dustry
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al Hy d oth	Bec	17. Father's Name	(First, Middle, I	Last)						18. Mother's N			Maiden .	Sumam	ө)	
Ment Ment arked atic	O_	Ferdinand	Pinnoc	k						Daisy	John	son				
2 sh and is m		19a. Informant's Na								and Number or F				Town,	State, Zip	Code)
1 and Health		Elise Murph 20a. Method of Disp		nter		20h P	Place of Disp			r. Beltsvi	Date	MD ZU/		ation	City or To	own, State
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/Medical		resulting in death)		Due t	o (or as	a conseq	uence of):									
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To the Hospital or Attendid within 24 hours after death. ₹o the Puneral Director: A completely tilled in by the fu	edicai	29a. Certifier (Check only one)	2 Medical E	R Physician: To the Examiner: On the	he best of basis of anner sta	examina	wledge, deat tion and/or in	h occurre vestigatio	d at the tim n, in my op	ie, date and plac pinion, death occ	ce, and courred at	due to the c t the time, d	ause(s) a ate and i	and mar place, a	ner as st nd due to	tated. the cause(s)
o the	Me	29b. Signature and	title of certifier	11/10	111101 318			25	Oc. License	number		2	9d. Date	signed	(Month.	Day, Year)
20			7/K4	10405	+				D4335	1				1/3		
	-	30. Name and addr	ess of person v	vho completed ca	use of de	eath (Item	1 23а) (Туре,	Print)								
)		Dr. lkechi (201 Greent	elt l	Rd. Su	ite U-1		llege	Park MD 2	0740					
Sta		31. Date filed (Mon	th, Day, Year) N 0 6 2	37	Registra	ar's Signa	ture	eadl o								
Registra	ar	JH	TIA A O S	_000	S COUR	1 10	- 1000	5000								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Yee PATRICIA A. PADGETTE 2006 10:40AM TAA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner YBENERAL HOSPITAL HOWARD COUNT HOWARD COLUMBIA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Director 217-28-8593 April 26, PA Usual Residence of Decedent with the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits s 23a or 28e-f show ust be notified at 1 Yes 2 No Howard Ellicott City Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5320 Dorsey Hall Drive #318 21042 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: itam 27 is marked other than "natural, or itams other traumatic evant, the Medical Exemples 11 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within. Dipartment of Health and Mental Hygiene. Importent: If item 27 is marked other training or other training. Grade 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James B. McKenna Anna Sailor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter Nancy Prior 7884 Savage-Guilford Road Jessup, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 01/09/2006 `4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 21. Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Kespiradon month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. E. it of Underlying Cause (Disease or injury Physician/Medical Examiner law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? mel 1 ☐ Yes 2 ☐ Yo 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) → opatient 1 ☐ Yes 2 3 3 4 6 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? e Hospital or Attanding P 24 hours after death. a Funaral Diractor: After t 28d. Describe how injury occurred Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I within 2 To the I 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D36845 Jan. 05, 2006

State

Registrar

7350

race

2006

don

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAI - CHI

32. Registrar's Signature

			For State Registrar		State	of Mar	yland		artmen tificat				lental Hy	giene	006	0	
1.8	Dhyciair		1. Decedent's Name	e (First, Middle,	Last)								2. Date of De Month	ath Day	Yea		3. Time of Death
	Physicia /Medic		Jack Per	rdue									Januar	y 4,	2006		4:55 P M
	Examin		4a. Facility Name (I			number)			-		r Location	of Death			County of D		
		e 42	Stella Ma			1				OWSC		- 04 Usa			altimo		
	Funeral		5. Social Security N		5.Sex †Y∑M 2☐F	7. Age (t birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	B. Date of Bir (Month, Da Februar)	th ay, Year) 7 10 1	022	Country Country	e (State or Foreign
16	Director	-	236-50-41 Usual Residence of	1	Λ	_	72	113.				ļ.,,,,	recruary	<u>/ 10, 1</u>	933	WV	
	land ow		10a. State	10b. County		1	10c. City,	Fown or Lo	cation			-				10d	. Inside City Limits
	Mary fish	ō	MD.	Baltimo	ore		Du	ndalk									1 ☐ Yes 2X No
	r 28a	Funeral Director	10e. Street and Nur						10f. Zip	Code				10g. Citi	zen of What	Country	?
	N with	0	1777 Broo	okview E	Road					2122	22			U	SA		
	ma 2	Jer	11. Marital Status		12. Was De	ecedent Ev Forces?	er in U.S.	13.	Was Dece	lent of H	ispanic Or	rigin? (Sp	ecify Yes or No Rican, etc.))-	14. Race - A		
₩.	or Its	Ī	1 Never Marr	ied 2 Marne		s 2 No Give			1 ⊡ Yes		Specify		rticati, etc.)		Black, W		
:55p.m 5-0036	ours iral',	d by	3 Widowed	4 Divorced	Year or	Dates:						•			Specify: W	hite	3
4:55p.	within 72 hours after death with the Maryland ene. than "natural", or Itema 23e or 28e-f show to Madical Extruition outst be coulded.	Be Completed	(Spec	15. Decedent's cify only highest	s Education grade complete	d)		16a. Deced (Give	dent's Usua kind of wo	d Occup	ation during mos	st of work	ing	16b. Ki	nd of Busine	ss/Indus	stry
	han han	dm	Elementary/Seco	ondary (0-12)	College	(1-4or 5+)				e retired	1)			Po+	hlehem	C+c	201
6 121	filed v Hygie other t	ပိ	8 years 17. Father's Name	(First Middle I	act)			Rol	тет		18 Moth	or's Nam	e (First, Middle			500	
4, 2006 Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event, Ite Marical Exposition count be notified at once.	Be	Earl Per		231/								llenwat		Jumamey		
7 2	should not marke	2	19a. Informant's Na		n (Type Print)			19h Mailir	na Address	(Street			al Route Numb		r Town State	a Zin Co	nde)
4, Ma	d 2 s th an t7 is traus	,	Betty Per			.fe			-				Dundalk				500,
	1 an Heall •m2	į.	20a. Method of Dis			.TE	20b. Plac	e of Dispo	sition (Nar	ne of		Janu			cation - City		n, State
JANUARY altimore,	Pages nent of int: If It iry or o		ty⊡ Burial 2		3 □Removal fro	m State	Oak	letery, crer Lawn	natory or c	ther plac ery	e)	7, 2	ary 006		dalk,M		
FI	artme ortani injury		21. Signatore of Fu					22	Name ac	d Addre							
Ba	Depa Impo any is		Chit	mu !	Com	elli		7	110 S	olle	ers P	oint	ome Of ROad,	Dunda	a1k,P. alk, M	A. D. 2	21222
- pro-			23a. Part1. Enter t shock, or hea	he disease, or o	complications that	t caused an each line	death.	Do not ent	er the mod	e of dyin	ig, such as	s cardiac	or respiratory a	rrest,		In	pproximate Iterval Between
	Physician		Immediate Cause disease or condition	(Final		STAG										0	nset and Death
	/Medical		resulting in death)			to (or as a			А								-
	Examiner		Sequentially list co	anditions	b												
27/	ם ב	ner	Sequentially list co if any, leading to in cause. Enter under	eriving	Due	to (or as a	conseque	nce of):									
8	executed in and ial-transit	Examiner	Cause (Disease or that initiated events	injury s	c												
90,	ate be executed hysician and ihe burial-transit	Ě	resulting in death)	Last	Due	to (or as a	conseque	nce of):									
8760	ate be hysicia the bur	lical		,	d					_						1	
9	ing p	Mec	IF FEMALE:													11	
30	death certifica e attending ph ed for use as ti	an/	23b. Was deceden			e birth 2	☐ Fetal d	eath 3	Ectopic pi		,			1 3	23d. Date of Month	delivery Da	ay Year
P.O. Box 68	the a	by Physician/Med	1 ☐ Yes 2 €	□No	4 □ Pre 9 □ Un	egnant at tir known	me of dea	th 5 [Other (sp	ecify)					1710		, 50
9.	d by	Phy	Part II. Other signif		te contributing to	dooth but	not cocult	na in the w	ndarh ina a	01100 011	on in Bad	1	23a Did	lobacco u	rea contribute	a to the	cause of death?
PERDUE of Vital Records,	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th		Part II. Other signif	neam condition	is contributing to	Jugain but	not result	ng in the u	nuenying c	ausa giv	en m ran	1.					ly 4 X Unknown
Ö	w req beer shou	Completed											24a. Was	an	24b. Were	autopsy	/ findings available
E e	he la has ge 2	Ę.				20.2							auto perfe	psy ormed?	prior death	to comp	letion of cause of
DU	in: T	ပ္	25. Was case refer	rred to medical					1017-0-0		ne Diae	o of Dogs	1 ☐ Yes		1UY	es 2	No
PERDUE	sicia cert lirect	To Be	examiner?		Hospital:	☐ Inpatient	2□ = 1	2/Outnation	4 3 C D	Oth			me 5 Res		E Wil Other /C	anaif.	HOCDICE
	Phy or this oral d	Ě	27. Manner of Deat			te of Injury		Bb. Time of		Bc. Injur Wor		ursing ric	28d. Describe			рөспу	HOSPICE
JACK	ading th. : Afte	it o	1 XNatural 2 ☐ Accident	5 Pending investiga		onth, Day	Year)	Injury	м		k? Yes 2.⊑]No					
JACK Division	Attending Physician: r death. sctor: After this certific by the funeral director.	Ifica	3 Suicide	6 Could no	289. Pla	ce of Injury	y - At hom	e, farm, str	eet, factor	, office			28f. Location (Rural A	loute Number,
á	al or	Certification:	4 Homicide		bu	ilding, etc.	(Specify)						City or To	wn, State)		
	To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	edical C	29a. Certifier (Check only	1X Certifying 2 Medical E	Physician: To the	the best of	my knowl	edge, death	n occurred	at the tir	ne, date a	nd place,	and due to the	cause(s)	and manner	as state	ed.
	the F tin 24 the F	ledi	one)			anner state											\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
	To To To To To To To To To To To To To T	Σ	29b. Signature and	titler of certifier)				290	. Licens	e number			29d. Dat	e signed (Mo		y, Year)
					/-					1)1	137	25			1/5/	06	
	3	- 1	30. Name and add														
				RIQ MAHM		00 DU			LEY R	D	TIMO	NTUM.	MD 21	093			
	Sta		31. Date filed (Mon			. Registrar	-										
	Registr	वा	JAN	0 6 200	16		H	Lieu	6								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Year **Physician** JANUARY 4116PM Ethel Louise Porter 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Baltimore 7. AGNES HOSPITAZ 8. Date of Birth June 28, 1913 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours **Funeral** Days 1 ☐ M 2 🗓 F Months Maryland 92 215-05-9389 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r then "naturel", or items 23s or 28s-f show 1 ☐ Yes 2X No Catonsville Baltimore Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 912 South Rolling Road USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Efementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Carrie Spittel John Fehrmann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 605 Southmont Road Catonsville, Maryland 21228 Richard W. Porter, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Loudon Park Cemetery 01/06/06 21. Signature of Funeral Server Liberte

Thomas Gregor ²² Name and Address of Facily NacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21220 eny ir 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC ADENOCARCINOMA OF COLON 4 EARS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by PNEUMONIA-1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident filled in by the Director 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier

State Registrar

2

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Records,

Division of Vital

ORIGINAL

P16766

900 CATONS AVENUE BALTIMORE, MO, 21229

2006

ASCOD, MD.

MASUDD,

31. Date fifed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 2008

32. Redistiar's Signature

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of F			ene	6 00113
×.			Decedent's Name (First, Michael Control of the	ddle, Last)				2. Date of Death	1	3. Time of Death
	Physic /Medi		Sai	muel Ellis	Padgett			January	3, 200	06 6:45 P ^M
	Exami		4a. Facility Name (If not institut	tion, give street and number)	4b. City, Town, or	r Location of Death		4c. County	
	.74 V	Ş.	1243 Francis				butus		Bal	ltimore
j.	Funeral Director		5. Social Security Number 169–12–5095	6. Sex 1 XM 2 ☐ F	ge (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 20,	^{Year)} 1920	9. Birthplace (State or Foreign Country) Pennsylvania
	land		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary -i eho	Ş	MD I	Baltimore			outus			1 ☐ Yes 2 🗖 No
	r 28a	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	
	th witt	Funeral Director	1243 Francis	Avenue			21227			USA
	dea	ner	11. Marital Status	12. Was Deceden Armed Forces	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-		- American Indian,
5-0036	72 hours after death with the Maryland *nature!', or Items 23a or 28a-f show sellical Exac iliner must be notilited at	þ	1 ☐ Never Married 2 【XM 3 ☐ Widowed 4 ☐ Divorc	arried 1 X Yes 2	No	1 ☐ Yes 2 X No	Specify:	rican, etc.)	Specify:	k, White, etc. White
5-0	72 ho	Completed	15. Deced	ent's Education hest grade completed)	16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of Bus	siness/Industry
2121	within ene. than	npie	Elementary/Secondary (0-12		5+) life.	DO NOT use retired	daning most of work	I	ndustr	
	filed w Hygier Ither ti		17. Father's Name (First, Middle	4		Salesman				g Supplies
Maryland	od of	Be			. + +		18. Mother's Name	e (First, Middle, M.		*)
Z	should nd Men marke	2	19a. Informant's Name/Relatio			ng Address (Street a	and Alumbor or Due	Ada	Hahn	7.0.11
M	and 2 s salth an n 27 ls isr trau		Patricia A. Pa			Francis A				
ନ୍	Hea Hea Ham	8	20a. Method of Disposition	agett, wile	20b. Place of Dispo	sition (Name of		Arbutus,		21227 City or Town, State
9	Pages nent of I int: If its		1 Burial 2 Trematio 4 Donation 5 Other	n 3 Removal from State (Specify)	1	matory or other place ematory,	· 1			
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If itam 27 is marked other than any rigury or other fraumatic event, Ins. M. 2006.		21. Signature of Funeral Service		MacNabb 2	Name and Addres	Society o	of MD, In	c.	more, MD
			23a. Part1. Enter the disease,	or complications that cause	$\perp 2$	99 Freder	ick Road	Raltimo	re MD	
			shock, or heart failure. L	ist only one cause on each	ine.		_	, 1	it,	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a mete	istatic	Cancer	ofpn	gratzo		Zyears
-26	Examiner			Due to (or as	a consequence of):					7
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
É	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1						
0	icate be executed physician and s tha burial-transit	EX	resulting in death) Last	Due to (or as	a consequence of):					
68760,	ate b hysic tha bi	edicai		d						
		Med	IF FEMALE:	00. 11						
Box	eath certif attending for use a	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date Mont	of delivery h Day Year
P.O.	the d	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant a 9☐Unknown	time or death 5	Other (specify)				
	that the		Part II. Other significant condi	tions contributing to death t	out not resulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	cco use contrib	oute to the cause of death?
Records,	quires in sign uld be	ed by						1 🗆 Yes	2 No 3	B Probably 4 Unknown
၀	aw requise been 2 should	Completed						24a. Was an	24b. W	ere autopsy findings available
æ	The tav ate has page 2	E O						autopsy performe	nd2/ pri	or to completion of cause of ath?
Vital	ian: ertifica ctor, p	Bec	25. Was case referred to medic	al			26. Place of Death		2 No 1 0	Yes 2 No
of V	Phyaician: this certificaral director, i	2	examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 Inpation	ent 2 ER/Outpatien	t 3 DOA Othe	-	ne 5 Residenc	ce 6 ☐ Other	(Specify)
0		 	27. Manner of Death 1 ☑Natural 5 ☐ Pend	28a. Date of Inju	lry 28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how	intury occurred	1
<u>S</u>	eat or:	cat		tigation		M 1 □ Y	es 2 □No			
Division	l or Att after d Direct d in by i	Certification:		mined 286. Place of In	ury - At home, farm, stre c. (Specify)	eet, factory, office	4	28f. Location (Stree City or Town, S	et and Number State)	or Rural Route Number,
	Hospitel Hospitel Hours a Funerel C		29a. Certifier	ing Physician: To the best	of my knowledge death	occurred at the time	e date and place of	and due to the en	(-)	
	To the Hospitel or a within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only 2 Medical one)	al Examiner: On the basis of and manner st	i examination and/or inv	restigation, in my opi	inion, death occurre	ed at the time, date	and place, an	d due to the cause(s)
	To the twithin 2. To the f	Σ	29b. Signature and title of certif	ier		29c. License	number	29d	. Date signed ((Month, Day, Year)
)	.1		1 Del	un		D3	5254	J	Januarv	4, 2006
	12		30. Name and address of perso	0.	0 1	Print)				
		3	31. Date filed (Month, Day, Yea	er mo 702	ar's Signature	ave b	ALTIM	one W	MD3	1229
	Sta Registr	_	JAN 0	R.	ar a digridure	86				
10.7		0	JAIN ()	D LUUD I Pola	e_ 13 182					

			FOI	artment of Health and Mei	ntal Hygier	Phos polly
			registral	rtificate of Death	Reg. 1	
	Physicia		1. Decedent's Name (First, Middle, Last)		Date of Death Month January	2006 3. Time of Death 9:30P M
	/Medic Examin		Myrtle S. Person 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	LAdiiiii		Heartland Healthcare Center			Prince Georges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 M 2 T F 87 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Yea	ar) 9. Birthplace (State or Foreign Country)
	Director	-	579-30-4450 X 87 Yrs. Usual Residence of Decedent	<u> </u>	Mar.22,	1918Virginia
	yland		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits 1 [XYes 2 □ No
	88-1-8	cto	Maryland Prince George Hyattsv:		100	Citizen of What Country?
	Mith th	Funeral Director	10e. Street and Number	10f. Zip Code 20783		ited States
	ns 23	era	6500 Riggs Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric		14. Race - American Indian,
•	or Itan	Fur	Armed Forces? 1 Never Married 2 Married I Yes, 2 Mo If Yes, Give	1 ☐ Yes 2X No Specify:	an, etc.)	Black, White, etc. Specify:
2	filed within 72 hours after death with the Maryland Hygiene. Hygiene, the Hygiene, or Itams 23s or 28s-f show ent, the Modical Examiner must be contified at ent.	d by	3 ☐ Widowed 4 X Divorced Year or Dates:	edent's Usual Occupation	16h	Black Kind of Business/Industry
2	in 72	Completed	(Specify only highest grade completed) (Giv.	e kind of work done during most of working DO NOT use retired)	100	. Killa of Basiness/Haastry
7	d with glene.	mo	Elementary/Secondary (0-12) 12th. BELL	ATLANTIC /VERIZO		lephone Communi-
2	al Hyg	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		cacion
<u>X</u>	Menid I Menidarke Marke Marke Marke	ဥ	Robert Henry Ryland 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Harriet ing Address (Street and Number or Rural F		Whitfield
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By Injury or other treumatic event, the Modral Examinar must be rediffied at once.		Mar Malton Dorgon (gon)			
נ	f Heal		cametery cre	Pine Ridge Court position (Name of part part of property of other place)	e 20c	Location - City or Town, State
2	Page nent o nnt: If ury or		1 Surial 2 Cremation 3 Hemoval from State 4 Departion 5 Other (Specify) Marylan	nd NationalJan.9,	'06 La	urel, Maryland
	epartr epartr nporte ny Inju		21. Signature at Functal Seprice Ligensee			Funeral Home
<u>.</u>	Ø □ = € □		23a. Part 1. Inter the disease, or complications that caused the death. Do not en			.W. Wash.D.C.2001
			shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) Cardiopulmonar Due to (or as a consequence of):	y Arrest		
	Examiner		Sequentially list conditions b			
	ait sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
6	be executed iician and burial-transit	Examiner	that initiated events resulting in death) Last C			
, 0 0	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	caiE	d			
0	certificat Iding phy Ise as th		IF FEMALE:			
XOO O	death ce ne attendi ad for use	Physician/Med	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
	the de y the s	ysic	1 Yes 2 No 9 Unknown			
7.	requires that the een signed by th hould be detache	by Pr	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I.	i	co use contribute to the cause of death?
cords,	aquire en sig ould b		Peripheral Vascular Disease		1 🗆 Yes	2 No 3 Probably 4 Unknown
ဝင္	es es es	Completed	Diabetis Mellitus		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
<u> </u>	T ate	Con			performed 1 Yes 2X	
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (in part 3 □ DOA Other: 4 ☑ Nursing Home		e 6 □Other (Specify)
0	ding Phys h. After this funeral di) -	27. Magner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28	d. Describe how i	
loli	Attending in death.	atio	2 Accident investigation	M 1 Yes 2 No		
UIVISION	al or Attendir s after death. I Director: Af d in by the fur	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28	f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	e Hospital or 1 124 hours after 16 Funerel Dire 1etely filled in b		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, an	d due to the caus	e(s) and manner as stated.
	To the Hospital within 24 hours a To the Funerel I completely filled	ledical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or and manner stated.			Date signed (Month, Day, Year)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. Lieense number	7 290.	Date signed (Month, Day, 1941)
	/		30. Name and address of person who completed cause of death (Item 23a) (Typ-	9. Print)		119100
	2		Dr.Nasreen M. Kango 7610 Carol		05 Tako	oma Park, Md.2091
	Sta		31. Date filed (Month, Day, Year) JAN 0 5 2006 Z. Registrar's Signature			•
	Regist	ar	JANU D LUUD ARTHUR ST. ST.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No." 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1301 PM Year TAN) **Physician** UOROTH' 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street, and number), Examiner University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 12 06 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 6. Sex Year) 19 **Funeral** Days Hours 1 M X X ΜĎ Director ឧ**7** 217-12-3221 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a State irel', or items 23s or 28s-f show Exar-it et musi be notified at 1√ Yes 2 No Director Baltimore NA MD 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21217 U.S.A. Apt 322 Eutaw Place 1701 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Yes 20 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify Completed by 3 ☐ Widowed 4 ℃ Divorced Black naturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Balto City Schools h and Mental Hygier 7 is marked other th Cook 10th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Betterman Willie Savage 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 is any injury or other tret once. 21215 Baltimore Md 4015 Rosecrest Ave, Thelma Savage-Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 1/7/06Arbutus, 21. Signature of Funeral Service Licer see 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) hemorrhage Examiner ntrucerebra e aquantially list auditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 10 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death within 24 hours after death. To the Funerel Director: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 03 2006 30. Name and address of person who compreted cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 , M.O

0 5

Mark larchi 31. Date filed Wonth, Day, Year) 22 South Greene Street.

32. Registrar's Signature

Baltinare, MD 2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Item #5 Per FH C851 1 Per FH C851 Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) □ay Month Year **Physician** January 4:10 AM ANTHONY L. PITTS , SR. 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** NIA VA Center Baltimore
If Under 1 Year If Under 24 Hrs. Medical Baltimore 5. Social Security Number
213 · 14 · 3007
Usual Residence of Decedent Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 01-06-1954 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**2** M 2□F Yrs. MD 51 Director the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other then "neturel", or Items 23s or 28e-f show other treumstic event, the Nedical Exercit entrainst by notified at 14 Yes 2 No Director BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 2922 WINCHESTER STREET abu 21216 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify. 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Importent: if tem 27 is marked other then "netu importent: other treumetic event, its Audical ADRS. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC NA 1214 GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JEFF W. PITTS DOROTHY M. SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2922 WINCHESTER ST. E DOROTHY M. PHIS (MOTHER) BALTO. MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method ol Disposition 1 ■ Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 01-09-06 GARRISON FOREST OWINGS MIUS, MD 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licensee Vangh 515) BALTO. NATE PIKE, BALTO. MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Immuno deficiency Human disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit that initiated events signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time ol death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 ☐ Yes 2 1 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA οĮ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After of or Attending Fafter death. 1 Xiatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Thomicide To the Hospitel of within 24 hours at To the Funerel D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 2006 M.D 19760 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTMORE, MD 10 N. GREENE ST. Lee M.D. 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JAN 0 5 2006

Lowell

Anthony

DHMH 17 Rev 1/2001

PARMAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 5: 15 AM ERNAR EDWARD 2006 an 02 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** NURSING HOME EVINDA E If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yes, last birthday) 5. Social Security Number 6. Sex 1. M 2 ☐ F **Funeral** Months Days Hours 216-05-01 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo MARYLAND 10g. Citizen of What Country? 10e. Street and Number 2 ö 23a by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 25 No Soecity: 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other than College (1-4or 5+) MANUFACTURING TH GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I OBERT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SON BURNIE MD. 21061 KOBERTJOHNSON HVE. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 0 Important: I any injury o once. -06 OWINGS MILLS 4 ☐ Donation 5 ☐ Other (Specify) BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2121 BALTO, MD 2da. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration **Physician** neumonin /Medical Due to (or as a consequence of) Examiner nhamn Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate be executed ereprovasco Box 68760. Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached t 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Prostat autopsy performe 2 🗆 No 1 Yes 2 **N**O 1 Yes certificate the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 ER/Outpatient 3 DOA this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 No investigation Diractor: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 160170 20 /06 rson who completed cause of death (Item 23a) (Type, Print) Name and address of pe evindale 2434 W. BELVEDERG AVE, BALTO MA 6 horthonn

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State

Registrar

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strar's Signature

2006

			For State 1 - State Registrer	-	artment of Health and Martificate of Death	Mental Hygien	1000 00112
	Physici /Medic	an al	1. Decedent's Name (First, Middle, Last) FLORENEZ MARY	PILKENTON		JEUNARY.	ay Year 5: 30 Å, M
	Examin Funeral Director	eı	4a. Facility Name (If not institution, give street and response to the stre		4b. City, Town, or Location of Death If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County CARTAN HOWARD	10c. City, Town or Lo	cation		10d. Inside City Limits 1 □ Yes 25 No
	ath with the	ral Director	10e. Street and Number 9394 Paulskirk Origin	/_	10f. Zip Code		itizen of What Country?
980	72 hours after death with the Maryland natural; or Items 23a or 28a-f show Jical Eracifiet mual be rediffed at	by Funeral	Amed	2 10 No	Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 254 No Specify:	Decity Yes or No-	14. Race - American Indian, Black, White, etc. Specify: WHitZ
21215-0036	within ene. than "	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	(Give life. I	dent's Usual Occupation kind of work done during most of work DO NOT use retired) LYTAKLY	king 16b.	Kind of Business/Industry AT Horse
Maryland 2		To Be C	17. Father's Name (First, Middle, Last)	Kowski	18. Mother's Nam	10.1	ROWKA
	1 and 2 s Health ar em 27 is ther trau		19a. Informant's Name/Relationship (Type, Print) Charles Plant Service 20a. Method of Disposition	20b. Place of Dispo	Providence Ro	AO TOWS	Location - City or Town, State
Baltimore,	permit. Pages Department of I Important: If it any injury or o		T Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify) 21. Surnauc of Funer (Service Licensee)	m State PARKWOE	- C - 1011.	JEWASSIT	Krille Marahano
	Physician		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition	t caused the death. Do not ent each line. Metastat	60.1.	-	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due	o (or as a consequence of):	euncer.		
00,	ate be executed hysician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	o (or as a consequence of):			
68760,	nificate by ng physic as the bu	Aedical	d				
O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant 1 Liv	gnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ecords, P.	w requires that the been signed by should be detact	by	Part II. Other significant conditions contributing to	death but not resulting in the u	nderfying cause given in Part I.		o use contribute to the cause of death? 2 DNo 3 Derobably 4 Dunknown
α	The ate h page	Completed				24a. Was an autopsy performed?	
on of Vital	ding Phys n. After this funeral di	tlon: To Be	27, Manner of Death 28a, Da	□ Inpatient 2 □ ER/Outpatier te of Injury onth, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing H	th (Check only one) ome 52 Residence 28d. Describe how inj	
Division	or in	Certification:	3 Suicide 6 Could not be 28e. Pla	ice of Injury - At home, farm, str ilding, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	(Check only 2 Medical Examiner: On the	the best of my knowledge, death basis of examination and/or in anner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause(rred at the time, date at	s) and manner as stated. nd place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	Smy	29c. License number D 34650		Date signed (Month, Day, Year)
	30		30. Name and address of person who completed of Tectives Cool MT	ause of death (Item 23a) (Type,	Print) rieg go Centar	Drive A	rry Hall 21128
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32	. Registrar's Signature	boardis		

			1 - For State Registrar	State of Mar		epartme <i>Certifica</i>			Mental F	lygiene Reg. No.	000	00120
	100	di	Decedent's Name (First, Middle, La	ast)					2. Date of	Death		3. Time of Death
	Physici /Medic		MACEL	REXA					Month	1 O	106	11.50AM
	Examir	er	4a. Facility Name (If not institution, gi					Location of Dea	ith		County of Death	
		A	JOHNS HOPKINS (5. Social Security Number 6.		In yrs. last birth		ler 1 Year	ORE	s. 8. Date of		*RYLA	
1	Funeral Director			1□M 2/2NF 59		rs. Month		Hours Min	. (Month,	Day, Year) 8,194	Cou	place (State or Foreign intry) Virginia
	P .		Usual Residence of Decedent 10a. State 10b. County		0c. City, Town	or Location						
	Aaryla Fehor	ō			oc. Oity, Town	Of Education						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-	Director	Maryland Balt 10e. Street and Number	imore		10f. 2	ip Code	D	<u>undalk</u>	10g. Citi	izen of What Cou	intry?
	h with	al Di	3427 Yorkway					21222		Un	ited Sta	ites
	deat	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dec	edent of H	ispanic Origin? (i n, Mexican, Pue	Specify Yes or	No-	14. Race - Amer Black, White	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or itame 23s or 28s-1 show other treumstic event, the Medical Examinat must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			2√ □ No	Specify:	, ,		Specify:	ite
5-0	"natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. I	Decedent's Us (Give kind of	vork done d	during most of wo	orking	16b. Ki	ind of Business/I	ndustry
121	within ene. than	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT		-			Ob immin	
d 2	Hygin Hygin other	Be Co	12 Years 17. Father's Name (First, Middle, Las	1)		Shippi	ng Ci	18. Mother's Na	me (First, Mid	dle, Maiden	Shippir	ig
/lan	Aental Aental rkad c	To B	Darius Clark Mal	.comb				Lona	Zella W	are		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Me		19a. Informant's Name/Relationship	(Type, Print) Broth	er 19b.	Mailing Addre	ss (Street a	and Number or R	Rural Route Nu	mber, City o	r Town, State, Zi	p Code)
	1 and 2 Health tem 27		Mr. Burton Rexr	oad				d Delt	S. Carre	17314		
Baltimore,			20a. Method of Disposition XXBurial 2 ☐ Cremation 3 €			r, crematory o	other plac	T. I.	Date		ocation - City or T	
Ħ.	permit. Page Department of Important: If eny Injury or once.		4 □Donation 5 □ Other (Special Signature of Funeral Service Lice		Deer F			y 1/5/2				Maryland
Ba	Depa Impo eny le		MORONON	10 Mm	solul	Duda-	Ruck	Funeral	Home o	f Dung	dalk, Ir land 21	222
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused th	e death. bo no							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. HYPOX	IC R	DODIA	470	RY F	AILLIR	E		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c		f):						
	LAdimilei	70	Sequentially list conditions,	b. ISCHE Due to (or as a c	EMIC		EBI	RAL	INJU	RY	2	5 BAYS.
H	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (01 as a 0	orisequence o	17.						
7,7	be executed sician and burial-transit	Exal	that initiated events resulting in death) Last	C. Due to (or as a c	consequence of	f):						
68760,	ificate be exec g physician an as the burial-tr	edical		d								
	entificate ling phys e as the		fF FEMALE:						7.5			
Вох	eath certi attending I for use a	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 [Fetal death	3 Ectopic				i lila	23d. Date of delive Month	ery Day Year
Ö	The law requires that the death cert lie has been signed by the attendin page 2 should be detached for use	Physician/M	1 Yes 2 No	4□ Pregnant at tirr 9□ Unknown	ne or death	5 Cther	specify)			-		,
٩.	res that igned b	by Pr	Part II. Other significant conditions	contributing to death but r	not resulting in	the underlying	cause give	en in Part I.	23e. D	id tobacco u	ise contribute to	he cause of death?
of Vital Records,	w require been sig should b		41						11	☐ Yes 2{	□No 3□Pro	babfy 4 Unknown
ဝ၁	e law re has bea je 2 sho	Completed							24a. W	as an	24b. Were aut	opsy findings available ompletion of cause of
<u>=</u>		Con							pe 1 ☐ Ye	rformed?	death? 1 ☐ Yes	
Vita	Physician; Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			0*50	26. Place of De				
of	Phys this al dii	. To	1 Yes 2 No 27. Manner of Death	1 Inpatient				4 🗆 IAMI 2111À	Home 5 ☐ Re		6 Other (Speci	<i>(</i> y)
on	ding P th. : After s funera	tlon	Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	'ear) In	jury	28c. Injury Work	(? Yes 2 ∐No	Est. Bustine	o trow injur	y occurred	
Division	Attendes octor	Ifica	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of frigury	- At home, fari	m, street, fact	ory, office		28f. Location	(Street and	d Number or Run	al Route Number,
۵	tal or rs afte al Dir ed in	Certification:	4 - Hornida	building, etc. (Town, State,)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 157 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of r miner: On the basis of ex and manner stated	ny knowledge, kamination and d.	death occurre /or investigati	nd at the time on, in my op	e, date and plac pinion, death occ	e, and due to to urred at the tim	he cause(s) ie, date and	and manner as s place, and due t	stated. o the cause(s)
	To the Tour	Σ	29b. Signature and title of certifier	1		2	9c. License	number	_	29d. Dat	e signed (Month,	Dey, Year)
	₽.		* Younne	X8UNI		7	H 260	64200 -	+358	01/	01/06	
	6		30. Name and address of person who	hysician: To the best of miner: On the basis of exand manner stated SWW Completed cause of deat SWW Completed cause of deat SWW Completed cause of deat SWW Completed cause of deat SWW Completed cause of deat	th (Item 23a) (1	Type, Print)	STEL	N RV	É			
7.5	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	-						
Div	Registr	23,	JAN 0 6 2	006 May 12	B	Goode	0					
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		1	For State Registrar	State of Man	-	artment of F			ene 006	00121
			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physici: /Medic		JoAnn Rash					January	2, 2006°	3:49 P M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	Location of Dea	ith	4c. County of D	
			2236 Thomas Run Ro			Bel Air	T - (2.11)			Marford
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		212-02-9013		51 Yrs.			June 6,	1954 N	Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	daryl f sho	៦	Maryland Harford		Be1	\ir				1 ☐ Yes 2 X No
	the 28a-	Director	10e. Street and Number		Del	10f. Zip Code		10	g. Citizen of What	Country?
	3a or		2236 Apt.B Thomas	Run Road		210	15		USA	4
	death ms 2	Funerai	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.			Specify Yes or No- rto Rican, etc.)	14. Race - A	merican Indian, /hite, etc.
9	or ite	큔	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 21 ☑ No	Specify:	no nican, etc.)		
8	72 hours effer death with the Maryland natural; or items 23s or 28s-f show disal Examiner must be motified at	1 by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					Specify: \[wurte
21215-0036	in 72 hours effer death with the Marylan "natural; or items 23s or 28s-f show redical Examinar must be trofiffed at	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup	during most of w	orking 1	6b. Kind of Busine	ss/Industry
121	d within giene. r then	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired Piver	1)		Scho	വിട
			17. Father's Name (First, Middle, Last)			LIVEL	18. Mother's Na	ame (First, Middle, M		7013
Maryland	중 후 후 후	Be	Robert Campbel	1				1 Irene C		
7	and Mentel is marked o	ဥ	19a. Informant's Name/Relationship (T)		19b. Maili	ng Address (Street		Rural Route Number,		e, Zip Code)
Ma	tr i		Lonnie L. Rash, Hu	ısband	2236	Ant B The	omas Run	Road Bel	Air. MD	21015
ē,	s 1 an f Heel item 2 other		20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Name of	(8)	Date 2	0c. Location - City	or Town, State
Ę	Peges ment of t ant: If ite ury or of		1 ☐ Burial 24 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,	Hemoval from State		ematory :	- 1	04/06	Baltimon	e, Maryland
Baltimore,	글로보급 .		21. Signature of Funeral Service Linens	88	2	2. Name and Addre	ss of Facility	Of Maryl	and Inc	
m	Deperment of the police once		Thomas Gregor	ye		299 Frede	cick Roa	d Baltimor	re, Mary	and 21228
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused th	e death. Do not en	ter the mode of dyin	g, such as cardi	ac or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Haussi	il					Onset and Death
	/Medical		resulting in death).	Due to (or as a c	consequence of):					
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	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a o	consequence or):					
	and and I-tran	хаг	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):					
8760,	cate be executed bhysician and the burial-transit	cai								
687	ficate phys	edic		0						
Вох	eath certific attending p	lan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of	delivery
ă	death a atte d for	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin		⊒Ectopic pregnancy ⊒ Other (specify) _			Month	Day Year
P.0	at the de by the tached	Physicia	9 Unknown	9Li Unknown				_		
S,	The law requires that the death certificate be executed sie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	inderlying cause giv	en in Part I.			e to the cause of death?
ıd	w require been sig should b							1 ☐ Ye	s 2 No 3	Probably 4 Unknown
Records,	e law re has be je 2 sh	Completed						24a. Was an autopsy	prior	autopsy findings available to completion of cause of
Œ	The I	ο.						perform 1 ☐ Yes 2	ed? death	n? ′es 2□ No
Vital	ician: T certificat rector, pa	Be (25. Was case referred to medical examiner?			100		eath (Check only one)	
of \	Physic this c	၉	IK tes 2 No	Hospital: 1 Inpatient			4 Nuising	Home 5 Resider		ipecify)at scene
n c	ding F h. After funera	io	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Y		Wor	yat k? Yes 2.XNo	C	haveled S	111
isi	or Attending Physicien: ifter death. Director: After this certifica in by the funeral director,	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, st	70	103 2/400	7		Rural Route Number,
Division	efter Direction by	Certification:	4 Homicide determined	building, etc.	(Specify) At Lu	•		City or Town,	State)	MAir, MD
_	Hospitai 24 hours e Funerai I tely filled		29a. Certifier 1 ☐ Certifying Phy	sician: To the best of	my knowledge, deal	th occurred at the tir	ne, date and pla	ce, and due to the ca	use(s) and manner	as stated.
	To the Hospital or Attent within 24 hours effer deatl To the Funeral Director: completely filled in by the	Medical	(Check only Nedical Examone)	iner: On the basis of ex and manner state	xamination and/or in	ivestigation, in my o	pinion, death oc	curred at the time, da	te and place, and	due to the cause(s)
	To th within To th comp	ĕ.	29b. Signature and title of certifier	·	2	29c. Licens	e number	29	d. Date signed (M	onth, Day, Year)
			Labraels	CR/K		0.C.1	1.E.	.Ta	nuary 3.	2006
•	1	1	30. Name and address of person who o	ompleted cause of dea	th (Item 23a) (Type			30	J.	2000
	•		ZABIULLAH	44		Penn Str	eet, Ba	ltimore, M	laryland	21201
	Sta		31. Date filed (Month, Day, Year)	32. registrar'	s Signature	130				
	Registr	ar	JAN 0 6 20	106 Distance	S. A.					

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** Calvin Charles Reichert January 2006 4:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 515 Fountain Drive Linthicum Heights Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 M 2 □ F 220-14-3727 81 Nov. 2, 1924 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Hem 27 is marked other than "natural", or Heme 23s or 28s-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or iteme 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Anne Arundel **Funeral Director** Linthicum Heights 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 515 Fountain Drive 21090 USA Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electric Company Crane Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William M. Reichert, Sr. Georgeanna Covell ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michele Anne Popp / Daughter 515 Fountain Drive, Linthicum Heights, Md. 21090 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Ite any Injury or ot once. Burial 2 Cremation 3 Removal from State Maryalnd Veterans Cem. 1/9/06 Crownsville, Md. 22. Name and Address of Facility Hubbard Funeral Home, Inc. f Fungral S wice License 21. Lighature 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) ung ances /Medical Due to (or as a consequence of) Heart failerre. Examiner uve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physicien and s the burial-transit and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 5 Other (specify) 4□Pregnant at time of death page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 \(\text{No} \) 1 Yes 2/1 No 1 Tes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 - Nursing Home 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3□ DOA 5. Residence 6 □Other (Specify) tuneral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1-ANaturat 5 Pending Injury ne Hospitel or Attendin 24 hours after death. ne Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medicai (Check only one) within 2 To the 29c. License number 29b. Signature and the of certifier D36900 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hay. 415 S. Crain Singa 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

				For State Registrar	State of Marylar	nd / Departme <i>Certifica</i>	ent of Health and ate of Death	Mental Hygie		00123
		Physicia		1. Decedent's Name (First, Middle, Last				2. Date of Death Month	Day Year	3. Time of Death
	1	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. C	ity, Town, or Location of De	Linuxxy	4c. County of Dear	th
		Funeral Director		5. Social Security Number 6. Se	7. Age (In vrs.) Yrs. If Uni	der 1 Year If Under 24 H			hplace (State or Foreign buntry)
		Maryland -1 show feed at	tor	Usual Residence of Decedent 10a. State 10b. County Parking		ty, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
		with the is or 28s	Direc	10e. Street and Number	alid On 11	10f.	Zip Code	10g	. Citizen of What Co	ountry?
	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23e or 28a-f ehow eny injury or other treumatic event, I'm Medical Examinations in titled at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Swidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 25 No If Yes, Give Year or Dates:	.S. 13. Was De	cedent of Hispanic Origin? specify Cuban, Mexican, Pus 2 2 No Specify:	(Specify Yes or No- orto Rican, etc.)	14. Race - Ame Black, Whit	
	15-00	in 72 hour n "naturel" Avalical Ex	Completed b	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's U (Give kind of life. DO NO	work done during most of w	rorking 16	b. Kind of Business	nite Industry
	d 212	ifiled with Hygiene. other the		17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Secret	18. Mother's N	ame (First, Middle, Ma	School iden Sumame)	
	ırylan	should be nd Mental marked matic ev	To Be	Luiai Filbei 19a. Informa Name/Relationship (7	ype, Print)	19b. Mailing Addr	ess (Street and Number or	nietta Bural Route Number C	SOFITO	
	Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 ho t of Health and Mental Hygiene. If item 27 is marked other then "natur or other treumatic event, the Medical		Paul T. Read 20a. Method of Disposition	20b. F		ry Boad +	Parker Ma		
	altimo	permit. Page Department o Important: if eny injury or once.		1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify, 21. Signature) of Funeral Service Vicense			and Address of Facility	7.2006 T	manium al Chapel	Meryland
	8	permi Depa impo eny in		23a. Part1. Enter the disease, or condishock, or heart failure. List only	Janothy	2800	Harford Rox	d Parkuili	e Mary	Approximate
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3/06 a	Э. Вох 68	death e atter id for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn; 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 Ectopic	c pregnancy (specify)		23d. Date of del Month	ivery Day Year
1	ls, P.	requires that the een signed by th nould be detache	β	Part II. Other significant conditions co	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.		-	the cause of death?
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7.	Vital	Physician: Th this certificate ral director, pag	o Be C	25. Was case referred to medical examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \)	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Othor	eath (Check only one)		7/ 202
Der	ion of	ft fer	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	Home 5 Residence 28d. Describe how		any) LI & Spree
B	Division	To the Hospitel or Attendity within 24 hours after death. To the Funerel Director; A completely filled in by the function of	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fac fy)	tory, office	28f. Location (Stree City or Town, S	t and Number or Ru Itate)	ural Route Number,
Es		e Hospil 24 hour te Funer	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exem	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death occurration and/or investigat	ed at the time, date and pla ion, in my opinion, death oc	ce, and due to the caus curred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
		Y somp	Me	29b. Signature and title of certifier	my Roley.	und !	29c. License number		Date signed (Mont.	h, Day, Year) 4, 2006
		18		30. Name and address of person who o	completed cause of death (Iter	m 23a) (Type, Print)	harles G.			
		Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa		•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year SYRITA J. ROUSE 2006 10:00 AM 01.04. 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PARK HEALTH CARE CATON SVILLE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Year) BALTIMORE Summit 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🗗 F 29-80,8283 Usual Residence of Decedent Yrs. MD 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 TYes 277 No MD BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CINNAMON CIRCLE 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COLLECTOR CREDIT CARD 12 TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HARRY ROUSE, JR. DELO13 NEWKIRK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE MOTHER DELOIS ROUSE 1231 KEVIN ROAD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State on son Park 01-10.06 4 □ Donation 5 □ Other (Specify) BALTIMOVE 21. Signature of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO, NATT. PIKE, BALTO. MO Vaughn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA RECTAL Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a nonsequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA

Examiner physicien and the burial-transit Physician: The law requires thet the deeth certiticate be executed Box 68760, by Physician/Medical attending p Division of Vital Records, P.O. been signed by the should be detached Completed certificete hes birector, page 2 s Be Certification: To After To the Hospitel or Attending d in by the

Physician

/Medical

Director

by Funeral

Completed

Examiner

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Director

Bhow

or than "natural", or items 23a or 28a-f show the Mudical Examiner must be notified at

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 is marked ot

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permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

1 ☐ Yes 2 No 27. Manner of Death
1 Avatural
2 Accident

29b. Signature and sle of certifier

5 Pending investigation 6 Could not be determined 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time date and different due to the object of manner as stated

ROAD.

29a. Certifier

3 🗌 Suicide

4 | Homicide

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. PHYSICIAN

OLD COURT

29d. Date signed (Month, Day, Year) 2006

Hann To completed cause of death (Item 23a) (Type, Print) 5310 30. Name and address of AVVERAHAL

JAN 0 5 2006

31. Date filed (Month, Day, Year) 32. Registrar's Signature

RANDALLSTOWN

State Registrar

DHMH 17 Rev 1/2001

within 24 hours at To the Funeral D completely tilled in

Medical

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Alice M. Runkles JANUARY 1925 01 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL AGNES BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day,) 0 2 / 1 4 / **Funeral** Birthplace (State or Foreign Country) 1929 1 □ M 2 MF 217-24-0472 76 Yrs Director Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location or Iteme 23a or 28a-f ehow 10d. Inside City Limits other traumatic event, the Madical Examinar must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1444 Forest Park Avenue 21207 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗡 No Specify: White Specify: þ 3 Widowed 4 Divorced "natural", Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Worker Retail Food Pages 1 and 2 should be filed in nent of Health and Mental Hygic int: If Item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Albert S. Miller Mary H. Marr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Skrelunas - Daughter 102 Woods Avenue Clen Burnie, Maryland 21061 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State remetery, crematory or other place)
New Cathedral
Cemetery Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ō permit. Page Department o Important: If eny injury or gace. 01/06/2006 Baltimore, Maryland Signature of Funeral Service 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Breast Physician carcinoma 2 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ been signe should be d To Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No certificate 2 XN0 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury death. 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours a To the Hospital 29a. Certifier Medical 🌠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) January 1 2006 Agnes George 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar		artment of rtificate of		ind Men		ieme 006	001	26
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	Funeral Director		230-50-7697	7. Age (In yrs. 82	/ast birthday) Yrs.	If Under 1 Yea Months Day		Min. 06	Date of Birth Month, Day, /28/19	Year) 23 Per	Birthplace (State Country) nnsylvan	
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	r 28a	Director	10e. Street and Number			10f. Zip Code			10	Og. Citizen of What	Country?	
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Baltimore, Maryland 21215-0036	inel',	d by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates: 145	-'46	Tes 243 N	о Ѕреспу:			Specify: Wh	nite	
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ary	should band Ment and Ment a marked		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Stre	et and Number	r or Rural Ro	ute Number,	City or Town, State	a, Zîp Code)	
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C	1		30. Name and address of person who con	mpleted cause of death (Itel	723a) (Type.	Print) Poule	way, a	hna b	المالي	ND 2140		
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last t	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, SEP 23	9. (Year)	Birthplace (State or Foreign Country) MD
	Director	-	Usual Residence of Decedent					3EL 23 1	1910	CILI
	iryland show	_	10a. State 10b. County	10c. City, To						10d. Inside City Limits 1X Yes 2 □ No
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lore	Pages 1 nent of He int: If itan		20a. Method of Disposition 1 ☐ Buriaf 2 ☑ Cremation 3 ☐ Removaf	rom State ceme	tery, cre	nsition (Name of matory or other place	(e)		20c. Location - City	
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uld be file Mental Hy rked oth	To Be (17. Father's Name (First, Middle, Last Eugene Simmons)		1	8. Mother's Nam Betty Ma	e (First, Middle, M e Blake	faiden Sumame)	
parimitions, Mailyiania, ATA 13-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or itams 23a or 28a-1 show any injury or other treumatic event, the Madical Examinar must be notified at apprecia		19a. Informant's Name/Relationship (Debra Johnson / S	Type, Print) Lster		ng Address (Street and rnmill Ct.				Zip Code)
ages 1 and of He		20a. Method of Disposition 1 Surial 2 Cremation 3 C 4 Donation 5 Other (Specia	Inditioval holli State		sition (Name of natory or other place) Park Ceme		Jan /	20c. Location - City o Baltimore,	
rmit. Pages pertment of portent: If it y injury or of		21. Signature of Funeral Service Lice	,,		Name and Address				raryland
Demi Depe impo		Lunda Suel	etter Mol	443 8	717 Green	Pastures	Drive Ba	ltimore, M	aryland 21286-
		23a. Part1. Biter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ente	er the mode of dying,	such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Narcotic, A		Cocaine Into	oxication			Oriset and Death
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tificate og phy as the			d					//	
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e law requires that the death certificate be executed hes been signed by the attending physicien and je 2 should be detached for use as the buriat-transit	Physician/Med	1 Yes 2 No	4□Pregnant at time 9□Unknown	of death 5□	Other (specify)			Month	Day Year
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aduire an sig							1 ☐ Ye	s 212No 30F	Probably 4 DUnknown
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vician: The iclan: The certificate I							Nes 2	ed? death3	s 2 No
ysicial ysicial is certif	o Be	25. Was case referred to medical examiner? XXX Yes 2 □ No	Hospital: 1 Inpatient	2 ER/Outpatien	1 00		h Check only one		
ding Physician: The h, After this certificate h funeral director, pege	11-11	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time of			me 5 Resider 28d. Describe how	w injury occurred U	
the fu	catic	1 □ Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 🛣 Could not b	1/2/06	12:26 A	M 1 ☐ Ye	s 2 No			
el or At s effer d ii Direct	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (S) Found Reside	pecify)	eet, factory, office		28f. Location (Stre City or Town, Baltimore	eet and Number of F State) 4109 Ha City, MD	Rural Route Number, Tris Avenue
To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physicompietely filled in by the funeral director, page 2 should be detached for use as the	edical (29a. Certifier 1 Certifying Pt (Check only one) 2 Wedical Exar	ysician: To the best of my niner: On the basis of exa- and manner stated.	knowledge, death	occurred at the time, estigation, in my opin	date and place, nion, death occurr	and due to the car	use(s) and manner a	is stated. le to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	0		29c. License r	number	29	d. Date signed (Mon	ith, Day, Year)
r. 0		Morrier Vo	ne Strell	/	00	CME		January 2,	, 2006
7 Drand		30. Name and address of person who		(Item 23a) (Type, I		Donn Ct	not D-1.	·	-11-01-001
d V St	ate	31. Date filed (Month, Day, Year)	32. Begistrar's S	ignature	111 1	ein str	eet balt:	unore, Mar	ryland 21201
Regist		JAN 0 6 2			rates				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year Physician 40 Katherine Snyder 2006 muara /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Halth and hehabilitation linter Hunder 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. April 19, 1921 Mary Land Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F 219-01-5195 84 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle ir items 23a or 28e-f ehov iner must be notified at 1 ¥Yes 2 No Director Harford Bel Air Md. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 U.S.A. 809 Maxwell Place death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1□ Yes 2☐ No Specify: white r then "natural", o þ 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Comple Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 8 vears 7 is marked other traumatic event, If 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lena (unknown) John Wiener 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health at
important: If Itam 27 is
any injury or other trau 809 Maxwell Place, Bel Air, Md. 21014 Frederick F. Snyder, Jr./son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 1/6/2006 Suitland, Md. Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Eugeral Service Licensee 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** heymonio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury Examine requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death | Check only one) Hospital: Other: Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director. To the Hospital or Atte within 24 hours after des To the Funerel Director completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1/X Certifying Physician: To the best of my knowledge, death occurred at the time, date and alone and due at the cause (s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D262172 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHOSIA, M-D 21014 MAYSST #102, BEL AIR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For Stata Registrar	State of M	aryland		artment rtificate			ind Me	ental Hy	gien	UUU)	0013	0 8
	Dhorita		1. Decedent's Name (First, Middle, L.	ast)							2. Date of De			ear	3. Time of D	Death
В	Physici /Medio		Joan Ann Se	edlar									2006	Bar	10:20	m q
	Examin		4a. Facility Name (If not institution, gi		r)				Location o			40	. County of			-
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	Funeral Director			Sex 7. A 1 □ M 2	nge (In yrs. last	Yrs.	If Under	Days	If Under 2 Hours	Min.	8. Date of Bi (Month, Da Oct. 1	th av Year 6,19	34	New	lace (State or it try) Jersey	Foreign T
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation							1	0d. Inside City	Limite
	Maryla	tor	Md. Baltimo	re			stown					>		''	1 TYes 2	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other treatmatic event, the Medical Exam but must be notified at ance.	Director	10e. Street and Number 428 High N	leadow Rd.			10f. Zip (211	36			10g. Ci	U.S.		try?	
	r death	by Funeral	11. Marital Status	12. Was Deceden	?	13.	Was Decede	ent of His	spanic Orig	jin? (Spec	cify Yes or No Rican, etc.))-	14. Race -			
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au	d be f antal l ced of	o Be	William Wenz								icC1 yn					
<u></u>	shoul nd Me mari	To	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a			Route Numb			ate, Zip	Code)	
	alth a 27 is		Edward J. Sed1	ar,Sr./S											D 2113	36
ore,	of He		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State		e of Dispo	sition (Nam natory or oth	e of her place)	Da	ate	20c. L	ocation - Cit	y or To	wn, State	
Ĕ	Pag ment tant: I		`4 □ Donation ★ Other (Spec			ergr	een M	1a u s	o1eu	ım 1,	/9/06	F	inksk	our	MD,	
Baltimore,	permit Depart Import any in		21. Signature of Juneral Service Lie	ensee		E	ckhard	Address It F	of Facility	1 Cha	apel,	P.A.			.117	
			23a. Part1. Enter the disease, or cor	nplications that cause	ed the death.	Do not ent	er the mode	of dying	, such as	OWN i	Rd., Or respiratory a	rrest,	s Mil.	s.	Approximate	
	Physician	: 11	shock, or heart failure. List only Immediate Cause (Final	- 0		- (A	vial	de	MI	MAG				ш	Interval Betwee	
	/Medical		disease or condition resulting in death)	a Due to (or a	MAST s a consequen	nce of):		1	6171	10-11-		_		+	10 71	
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	res that thigged by	by Ph	Part II. Other significant conditions	contributing to death	but not resulting	ng in the u	nderlying ca	use give	n in Part I.		23e. Did 1	obacco	use contribu	ite to th	e cause of dea	ath?
rds	w require: been sig should b	ed b	HEART	PAILUR	٤						1 🗆	Yes 2	√° 3[] Proba	abiy 4 🗀 Uni	known
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	yalcian: is certific director,	o Be	25. Was case referred to medical examiner?	Hospital:	tiont 2 TER	/Outpatien	= it 3 □ DOA	Othe		of Death	(Check only o		C [] Other	(Cit		277
of	ding Phys Ih. After this funeral di	-	27. Manner of Death	28a. Date of In	jury 28	Bb. Time of		c. Injury Work		-	8d. Describe		6 ☐Other (<i>Specity</i>		
<u>o</u>	nding ath. r: Ate	atio	1 Accident 5 ☐ Pending investigation	(Month, D	ay rear)	Injury	М		? es 2□N	io						
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į.	To the within To the comp	Ň	29b. Signature and title of certifier				29c.	License 7	number 773	0		29d. Da	te signed (A	Aonth, E	Day, Year)	
r			30. Name and address of person who	completed cause of	death (Item 23	Ba) (Type	Print)	V	11)				10/0	5		
	10		GAM CINCA	MD. 6	169	N.		Anc	01	11.	34	To	,7%	' 2	1204	
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			1 - For State Registrar	State of Maryla		artment of H			giene Reg. No. 006	00131	
	Physici	an	Decedent's Name (First, Middle, Last)	Emma N. Sac	ha			2. Date of Dea	Day Year	3. Time of Death	
	/Medic	al	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of D	Januar	y 2 2006 4c. County of Deatl	8:00 P. M	
	LXaiiiii	CI	1611 Concordia D			Pasade			Anne Aru		
	Funeral Director	5. Social Security Number 220 22 7708 6. Sex 1 M 2 F 7, Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. 8. Date of B. (Months) Oct. 2							h y, Year) , 1928 Mar	nplace (State or Foreign untry)	
	D		Usual Residence of Decedent	17				0ct. 27	, 1920 Mar	yland	
	show	ž	10a. State 10b. County Maryland Anne Art		City, Town or Lo Pasader					10d. Inside City Limits 1 ☐ Yes 2 No	
	28e-f	rect	10e. Street and Number	mder	rasagei	10f. Zip Code			10g. Citizen of What Co		
	72 hours after death with the Maryland natural', or Items 23s or 28e-f show dical Examinar must be notified at	Funeral Director	1611 Concordia	Drive		211	.22		U.S.	, .	
	er dea Itema	uner		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? In, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Amer Black, White		
036	urs aft	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		1□Yes 2【No	Specify:		Specify: Wh	ite	
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ylaı	2 should be and Mental is marked (ToE		E. Burns				nora Taylo			
Maryland 21215-0036			19a. Informant's Name/Relationship (Type Virginia Milbourn	_{pe, Print)} .e / Daughter		ng Address <i>(Str</i> eet a Concordia			er, City or Town, State, Z ena, Marylar		
	is 1 and of Health Item 27 other to		20a. Method of Disposition	201		sition (Name of matory or other place		Date	20c. Location - City or		
Baltimore,	Pages ment of I ant: If Its ury or o		1 ^{Mag} Burial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)		len Have	en Mem. Pa	$_{ m ark}$ $ 1/\epsilon $		Glen Burnie		
Balt	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service License	ee					eral Servic		
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687	death certificate be executed e attending physician and of for use as the burial-transit	an/Medical	d	l							
Вох	leath certific attending p	an/M	230. Was decedent pregnant	3c. If yes, outcome of pred 1 Live birth 2 ☐ F		Ectopic pregnancy			23d. Date of deliv	. ,	
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of Vital Record	as b	ompleted	Hypertens	10~				24a. Was a autop	sy prior to c	opsy findings available ompletion of cause of	
alF		e Col	25. Was case referred to medical					perfor 1 ☐ Yes	2 No 1 □ Yes	2 🗆 No	
f Vii	di is	To B	examiner?	lospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe		Death (Check only or g Home 5 Thesid		ifv)	
	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	Work			ow injury occurred		
Division	Attending r death. ector: After by the fune	ertiflcation;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	t home, farm, str		Yes 2 □No	28f Location (S	Street and Number or Rui	ral Route Number	
	s after s after al Dire	Certi	4 Homicide determined	building, etc. (Spe	ecify)	oot, radioty, diffee		City or Tow		arriodio riambor,	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my liner: On the basis of exam	knowledge, death ination and/or in	n occurred at the tim vestigation, in my op	ne, date and pl pinion, death o	ace, and due to the occurred at the time, o	cause(s) and manner as date and place, and due	stated, to the cause(s)	
	To the h within 24 To the F complete	Me	29b. Signature and title of certifier	1/11		29c. License	number	2	29d. Date signed (Month	, Day, Year)	
	1		Juchard B.	Wilhams !	no	DI	8807	7	1/3/0	6	
	5		30. Name and address et person who co	mpleted cause of death (I	tem 23a) (Type,	Print)	wer Sh	· Raltin	more M	021275	
	S . Sta		31. Date filed (Month, Day, Year)	32. Sigistrar's Sig	nature	1 500	/ 1 / 1	1	70.6,7.1	y ~ 1000	
	Registr	ar	IAN 0 6 20	no Besus	J. A						

		į.	1 - For State Registrar		Maryland /	Departme		ealth and N Death		Reg. No.	6 0013	2
	Physici /Media		1. Decedent's Name (First, Middle,	Last)	mitt	^			2. Date of De Month	Day	Year 6 30	A-M
	Examir		4a. Facility Name (If not institution,	give street and number	r)	4b. Ci	y, Town, or	Location of Death		4c. County	ol Death	
	3			112 Cornish L				Pasa			Anne Arundel	
6-	Funeral			6. Sex 7. A 1 ☐ M 2√2 F	Age (In yrs. last	Yrs. Month	er 1 Year s Days	II Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	Birthplace (State or I Country)	Foreign
	Director		216-22-3446 Usual Residence of Decedent	X-	78	113.			Apr 8	, 1927	Maryland	
	land ow		10a. State 10b. County		10c. City, To	own or Location					10d. Inside City	Limits
	Mary	to	Maryland Ann	ne Arundel			Pa	sadena			1 X Yes 2	2 🗆 No
	r 288	Director	10e. Street and Number			10f.	Zip Code			10g. Citizen of \	What Country?	
	h with	a D	112 Cornish Lane					21122			U.S.A.	
	72 hours after death with the Maryland hatural, or Items 23s or 28s-f show dical Exacting Invest be rectified at	by Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13. Was De	cedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No	- 14. Rac	e - American Indian,	
9	after or its	T.	1 X Never Married 2 ☐ Marrie				2 No	Specify:	rican, etc.)	Specifi	ck, White, etc.	
21215-0036	urai',	d b	3 Widowed 4 Divorced	Year or Dates						Specify	Black	
5	"nat	Completed	15. Decedent's (Specify only highest	s Education t grade completed)	1	6a. Decedent's U	work done o	during most of work	ing	16b. Kind of B	usiness/Industry	
12	within ane. than "	ш	Elementary/Secondary (0-12)	College (1-4o	r 5+)	`life. DO NOT		todian		Anne Aru	ndel County Colle	ege
d 2	Hygie Hygie Sther		12 17. Father's Name (First, Middle, L	.ast)				18. Mother's Nam	e (First, Middle,	Maiden Suman	ne)	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Heath and Mental Hygiane. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Mudical Exercities increase to a refilled at	To Be		m H. Smith						ice S. Smith	•	
Man	d 2 sho th and 7 is mu trauma		19a. Informant's Name/Relationshi	ip (Type, Print)	1	•		an <i>d Number</i> or Rui ne Pasadena		er, City or Town,	State, Zip Code)	
	1 and 1 Health em 27	1	20a. Method of Disposition		20b. Place	of Disposition (A	lame of	1	Date	20c. Location -	City or Town, State	
101	Pages nent of I int: if it		1 X Burial 2 Cremation		(8	etery, crematory o			01/11/06		sadena, Md.	
Baltimore,	permit. Pages 1 and Department of Health important: if Item 27 any injury or othar tr once.	1	4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L.		N	At. Zion Chu		netery is of Facility	01/11/00	Га	Saucita, IVIU.	
Ba	permit. Departnimports any inju		Poud	Eat	00			others Funer taw Place Ba	al Service,	P. A.		
	Physician		23a. Part1. Enter the disease, or o shock, or heart lailure. List o	complications that cause only one cause on each	ed the death. D	Do not enter the m	ode ol dying	Taw Place Ba g, such as cardiac	i ltimore, Mo or respiratory a	12121/ rrest,	Approximate Interval Betwe Onset and De	
100	/Medical		disease or condition resulting in death)	aDue to (or a	as a consequenc	ce of):	1	3			year	<u>~</u>
4	Examiner		Sequentially list conditions	ь								
Щ	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequent	ce ol):						
	be executed icien and buriat-transif	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
30,	oe exe	<u>G</u>	resulting in death) Last	Due to (or a	as a consequent	C e ol):						
8760,	cate be exphysicien the buria	dlcal		d								
9 ×	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transif	Physician/Me	IF FEMALE:	23c. Il yes, outcom	ne of pregnancy					221.5		
Вох	res that the death cenigned by the attendinbe detached for use	lan	23b. Was decedent pregnant in the past 12 pronths?	1 Live birth	2 Fetal death	ath 3 ☐Ectopic				23d. Da	te of delivery inth Day Yea	ar
P.O.	the d	yslo	1 □ Yes 2 Ø No 9 □ Unknown	9□ Unknown		3 - 0 (116)	3pec#y)					
	that ned b		Part II. Other significant condition	ns contributing to death	but not resulting	g in the underlying	cause give	en in Part I.	23e. Did to	obacco use cont	ribute to the cause of dea	ath?
Records,	purres n sign	d by	Disabet	es					1 🗆 🗅	Yes 2□No	3 Probably 4 Doni	known
S	w requir	Completed	, and the second						24a. Was	an 24b.	Were autopsy lindings av	ailable
Re	Tha lav	E C							autop perfo	osy ormed?	orior to completion of cau death?	se of
ta			25. Was case referred to medical					26. Place of Deat			1 ☐ Yes 2 ☐ No	
of Vital	Physician: this certificated ral director, i	To Be	examiner?	Hospital: 1 ☐ Inpa	tient 2 ER/	Outpatient 3	OCA Othe			dence 6 ☐Oth	er (Specify)	
0	g Ph er thi	n: T	27. Manner of Death	28a. Date of in		b. Time ol Injury	28c. Injury Work			how injury occur		
jo	Attanding r death.	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Jay 1 dai/	М		Yes 2□No				
Division	r Atta er de recto	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	nod 288. Place of I	njury - At home etc. (Specify)	, farm, street, fact	ory, office		28f. Location (S City or Tov		er or Rural Route Numbe	91,
	ital or A rs after ai Dire			,	, ,							
	To the Hospital or Attanding Phwithin 24 hours after death. To the Funaral Director; After thi completely filled in by the funeral.	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the besixeminar: On the basis and manner:	of examination	dge, death occurre and/or investigati	ed at the timon, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and ma date and place,	inner as stated. and due to the cause(s)	
	within To the Comple	Me	29b. Signature and title of certifier			2	9c. License	number		29d. Date signe	d (Month, Day, Year)	
	. >- 0		MU I	ND			04	770	4	1/0	4/05	
	1		30. Name and address of person w	who completed cause of	f death (Item 23	a) (Type, Print)	1	1- 5 1		· · ·		
	7.4		31. Date liled (Month, Day, Year)	m np	7 3 5 strar's Signature	Ague	her	-T Rol	ble	-Jurn	no	
	Sta Registi		JAN 0 6 2006	Alegare)	A Signature	ach						

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l l				1 - For State Registrar	State of Ma		tificate of		Reg.	2000	00133
MY		3.7	হ ্ল	Negistrar Decedent's Name (First, Middle, Las	t)		imouto or i	<i>-</i>	2. Date of Death	NO.	3. Time of Death
34		Physici		Cynthia S	amantha	Smit	h		January	3,2006	
1		/Medic Examin		4a. Facility Name (If not institution, give				r Location of Death	-	4c. County of De	
				Joseph Richey	Hospice		Balti			n/a	
4		Funeral		5. Social Security Number 6. S	□ M 2127 F	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. E	Birthplace (State or Foreign Country)
3	• de →	Director		213-22-6792 Usuel Residence of Decedent	-	80 Yrs.			July26,1	.925 M	laryland
-3		yland		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
13/01		Mar al	ţċ	Md. n	/ a	Balt	imore				1 TyYes 2 □ No
1		or 28	Jre(10e. Street and Number			10f. Zip Code		10g.	Citizen of What	Country?
		ath w	ra I	35 N. Lakewoo		Apt.202		1224		USA	
		er de	une	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13. \	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
4	36	Ir, or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ ↑ If Yes, Give Year or Dates:		I□Yes 2☑No	Specify:		Specify:	White
SHITH	9	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or Iteme 23a or 28e-f show event, the Medital Examinar must be possible date.	Completed by Funeral Director	15. Decedent's Eq	ucation	16a. Deced	lent's Usual Occup	ation	165	. Kind of Busines	ss/Industry
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V)	21	filed wi Hygien ther th	Con	12th		S∈	cretary			Advert	ising
4	ng	be filed ntal Hygi od other svent, I	Be	17. Father's Name (First, Middle, Last)	M-C-11:				(First, Middle, Mai		1
-	Σ	2 should be f and Mental h is marked of raumatic sve	2	Samuel Lester 19a. Informant's Name/Relationship (7)			a Address (Street		Rosezell		ylor
YNTHIA	S	s 1 and 2 should f Heelth and Mer tem 27 is marke other traumatic	13	Carole Lynn St							yland21224
3	စ်	Heelth tem 27 other tr		20a. Method of Disposition		20b. Place of Dispo				. Location - City	
5	E O	Pages nent of I int: if It		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State /)	Bayview			,06 Ba	altimor	e, Maryland
	Baltimore, Maryland 21215-0036	permit. Pag Department Importent: f sny injury o		21. Signature of Funeral Service Licen	Mar l						al Home, PA Id. 21224
		Y.		23a. Part1. Enter the disease, or com	olications that caused	the death. Do not ent					Approximate
4		Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each in	c alocativist	- 6 mil.		10- 01		Interval Between Onset and Death
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	7	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events	Due to (or as	a consequence of):					
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	687	ificate g phy as the	edlo		. d						
	Box 68	eath certificate be executed attending physicien and for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy	,		23d. Date of c	*
	B.	deat	sicla	in the past 12 months? 1 Yes 2 No	4☐Pregnant at		Other (specify)	'		Month	Day Year
	P.O.	at the d by the	Phy	9 Unknown		A series of the			OGo Didasha		
	Division of Vital Records, P.O.	Hospitel or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate hes been signed by the attending physicien and telly filled in by the funeral director, page 2 should be detached for use as the burial-transit		Part II. Other significant conditions o	ontributing to death of	ut not resulting in the ui	nderlying cause giv	en in Paπ i.	1 ☐ Yes		to the cause of death? Probably 4 Dunknown
	000	law rees bee	Completed						24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
	Œ	The ate h	Som						performed 1 ☐ Yes 2 ☑	No 1 ☐ Y	? es 2□No
	/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?	Hanning.		T 011		(Check only one)		1
	of	Physi this c	-T	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatie			4 Nursing Ho	me 5 Residence 28d. Describe how i		oecity) Hespice
	o	ding h. After fune	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day	Year) Injury	Wor	rk? Yes 2 □ No	200. 2030100 110# 1	njary occurred	
	İSİ	Atten r deal sctor:	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ury - At home, farm, str	eet, factory, office		28f. Location (Stree	t and Number or	Rural Route Number,
	ā	s afte	Certification:	4 Homicide	building, etc	c. (Specify)			City or Town, S	rare)	
		To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on the basis of and manner sta	of my knowledge, death i examination and/or in- ited.	n occurred at the tirvestigation, in my o	me, date and place, ppinion, death occurr	and due to the cause ed at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
		To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29d.	Date signed (Mo	onth, Day, Year)
				> 20 100 M	D		102	41 10	Jay	Mary 3,	2006
		3		30. Name and address of person who	completed cause of d	eeth (Item 23a) (Type,	Print)	R. i.G.	MD -	21701	
	1	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	8. T. AT	in i ju	16119	-1	
	2	Regist	rar	JAN 0 6	2006	mes St A	BULL				

				Maryland / Depa	artment of Health and rtificate of Death	•	2006	00134		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) CHRISTINE	ROSE	SIMON	Januar		3. Time of Death		
	Examin		4a. Facility Name (If not institution, give street and number CARROLL HOSPITAL CE	NTER	4b. City, Town, or Location of De	R	c. County of Death			
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. / 1 ☐ M 2 ☐ M 2 ☐ M 2 ☐ M 2 ☐ M 2 ☐ M 2 ☐	Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 H Months Days Hours M		9. Birthp Goun	place (State or Foreign htry)		
	Maryland -f show	or	10a. State 10b. County Md Carrol1		1	0d. Inside City Limits 1 X Yes 2 □ No				
	with the	Direct	10e. Street and Number 7200 Third Avenue		10f. Zip Code 21784	10g.	Citizen of What Coun	itry?		
980	iit. Pages I and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortent: If Itam 27 is marked other than "natural", or Itams 23s or 28e-f show injury or other traumatic avent, the Modical Examinar must be routilled at ag.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 If Yes, Give Year or Date:	XNo	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White, Specify: whi	etc.		
21215-0036	filed within 72 ho Hygiene. Ither than "natur: snt, the Wed Fall.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	(Give life.	dent's Usual Occupation kind of work done during most of v DO NOT use retired) istered nurse	vorking	Kind of Business/Inc	dustry		
Maryland	old be filer lental Hyg ked othe Ic avent,	To Be C	17. Father's Name (First, Middle, Last) Anism Atanasu			lame <i>(First, Middl</i> e, <i>Maid</i> Hancher	len Sumame)			
Mary	nd 2 should be Ilth and Mental 27 is marked o r traumatic ave	-	19a. Informant's Name/Relationship (Type, Print) Theodore C. Simon (spouse		ng Address (Street and Number or Third Ave., Syk			Code)		
Baltimore,	Pages 1 and ment of Health ant: If Itam 27 ury or other tr		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from Sta 1 ☐ Donation 5 ☐ Other (Specify)	All Count	ty Cremation 1-	6-06 Syl	Location - City or To Cesville,	Md		
Ball	pernit, Pag Department Important: any njury c	All County Cremation Sykesville, Fide 22. Name and Address of Facility Haight Funeral Home & Ch. P.O. Box 195 Sykesville, Md 21784								
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A SEPTIC SHOCK Due to (or as a consequence of):									
	Examiner	ler		ELMON I	A			DAYS		
7,092	death certificate be executed e attending physician and id for use as the burial-transit	icai Examiner	MA	YEARS						
99	leath certificate attending phys I for use as the		IF FEMALE:							
.O. Box	that the death co ed by the attend detached for us	Physician/Med	23b. Was decedent pregnant 23c. If yes, outcome 1 Live birth	2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i>		23d. Date of delive Month	ny Day Year		
rds, P	The law requires that the ate has been signed by the bage 2 should be detache	by	Part II. Dther significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to th	e cause of death? ably 4 ∐Unknown		
al Records,		Completed				24a. Was an autopsy performed 1 Yes 2 A	prior to con	osy findings available inpletion of cause of		
Vital	Physiclen: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpa	tient 2 ☐ ER/Outpatier		eath <i>(Check only one)</i> Home 5 Residence	6 □Other (Specific	d)		
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Division	To the Hospitel or Attanding within 24 hours after death. To tha Funaral Diractor: Atter completely filled in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	njury - At home, farm, st etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Street City or Town, St		l Route Number,		
	To the Hospitel within 24 hours To the Funeral completely filled	Medicai	29a. Certifier (Check only one) Certifying Physicien: To the be 2 Medicel Exeminer: On the basis and manner	of examination and/or in	h occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)		
	To the within To the comp	M	29b. Signature and title of certifier A - J , Helory A	1,1	29c. License number DOO 176 Print) ARROLL HOSPAN	95 Jan	Date signed (Month, L	Day, Year)		
	8		30. Name and address of person who completed cause of ABDALLAH 3_HELOU, A		ARROLL HOSPOT	TL CENTER	WEST.	MINSTEL		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regular 32. Regular 32. Regular 32. Regular 33. Regu	strar's Signature	nous l					
DH	IMH 17 Rev 1/2	001		- 10 /cg						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🖗 🕕 🖯 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Roland N. Shaffer Jan. 11:00 a M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Longview Nursing Home Manchester Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 212-03-5268 1 1 M 2 □ F 92 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location item 27 ie marked other than "naturel", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Maryland Carroll Manchester, Md. Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21102 3101 S. Main St. U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Ie marked other than "naturel", or itel 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: à Specify: White 3 √Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor of Maintenance Towson University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester M. Shaffer Hilda R. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3275 Farm In. P.O. Box 914, Manchester, Md. 21102 Hugh N. Shaffer - son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. New Lutheran Cem. Jan. 7,2006 Manchester, Md. * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Chapel P.A. Manchester, Huth Pellit 6 Charmil Nd. 21102 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** interior /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Examiner as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medicai IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by þe 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours after To the Funerel Dire 15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the

0

State Registrar 29b/Signature

and title of certified

5 2006

31. Date filed (Month, Day, Year)

32. Registar's Signature

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month JiA 1655 PM SU JANUARY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA HOPKINS BALTIMORE HOSPITAL Johns If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** Min. 1□M 3□F Months Days 9 Hours NIA Yrs. CHINA Director 3,1986 APRIL Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location to Heath and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28e-f ehow or other traumatic event, the Mulical Experiment must be multipled at 10d. Inside City Limits NIA NIA 1 ☐ Yes 2 ☐ No SHANGHAI Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #4 2088 WAN HAVE DU RS Room 1202 20005 HINA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2☑ No Specify: CHINESE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA 13+4 Never WORKED 140 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any njury or other traumatic event 9008. 18. Mother's Name (First, Middle, Maiden Sumame) Be DUANTEN Ren XIAOXING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #4 2088 50 XIAOXING FATHER 100m 1202 WAN HANG DU RD. SHAMA hair Ching 200051 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 16 06 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMETORY BALTO. MD 21 Signature of Funeral Service Licensee 22. Name and Address of Facility STellA FUNERAL HOME CATP. HARTLEY WILLE STELLA FUNERAL HOME CATP. 7527 her foll M. BALTO. M. 21234 Julla 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hyperkalenia 72 hours /Medical Due to (or as a consequence of): Examiner +2 hours UCUTE RENal FAILUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit and Due to (or all a consequence of) Box 68760. ed by the ettending physicien detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 DUnknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 20 No 1 🗌 Yes 3 Probably 4 Unknown To the Hospitel or Attending Physician: The law requir within 24 hours effer death.
To the Funerel Director: After this certificate has been si compleate! filed in by the tuneral director, page 2 should Completed 24a. Was an autopsy performed?
1 Yes 25 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -000 JANUARY 2, 2006 Res 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Brown

5

31. Date filed (Month, Day, Year)

MS

600

32 Registrar's Signature ___

N WOIR ST. BILL MS 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 - State Registramend Item #9 Per FH C851 1/05% in the of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Francis Joseph Sheriff 1:45 A M JANUARY 3,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | Sept. 8 1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F Director 043-22-5732 Yrs 77 CI Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28e-f ahow other treumatic event, the Madical Exeminer must be notified at Director 1 ☐ Yes 2 No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Bandon Ct. #101 21093 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No If Yes, Give Year or Dates: 51-72 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify. 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Retired Colonel Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ss 1 and 2 should be fi of Health and Mental H Item 27 is marked of Memet Sheriff Elisima Trudeau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Hunters Ridge, Winfield, <u>Kenneth R. Sheriff/son</u> W. VA 25213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other moval from State Metro Crematory 5 Other (Specify 1/6/05 Catonsville, MD jonalus per ingril epirica L 22. Name and Address of Facility Bryan W. Clary

Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Applianced to Cause (Text). Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of) Examiner ISCHEMIC CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à END STAGE RENAL DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 rmed? 220 No certificate 1 ☐ Yes 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No 1 Tes 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Injury at Work? After Injury 1 Natural 2 Accident 5 Pending s after death. investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Baltimore, Maryland 21215-0036 P.O. Box 68760, Division of Vital Records, o the Hospitel or Attending Physicien: filled in by the within 24 hours after To the Funerel Dire Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06 541 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. LIM. M. D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Carried & Registrar JAN O 5 2006 DHMH 17 Rev 1/200

00138

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23e or 28a-f show eny injury or other treumetic event, the Medical Examinar must be motified at once.

Baltimore, Maryland 21215-0036

Physician /Medica Examine

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	1. Decedent's Nam	e (First, Middle, Las	st)					:	2. Date of Dea			3. Time of	Death
cian	David We	st Shecke	11s, Jr.						Month January	7 O1.	2006	4:35	АМ
lical iner	4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	r Location o		o arraar,		unty of Deat		
	Harbor	Hospital	Center			Baltim	ore				N/A		
1	5. Social Security N	lumber 6. S	ex 7. Age	(In yrs. la	st birthday	If Under 1 Year Months Days	If Under 2 Hours		8. Date of Birth	Year)	9. Birti	hplace (State or	Foreign
r	217-88-3	642	⊠M 2□F 4	3	Yrs.	leionais Days	Tiodis	0	8/07/19	62	Mar	yland	
	Usual Residence o	f Decedent 10b. County		10a Cibe	Taura and							104 114- 01	. 1.2245
_				-	Town or L							10d. Inside Cit 1. Yes	
octo	MD N/A Baltimore												
Ore	10e. Street and Nu					10f. Zip Code			1		of What Co	•	
ra	3512 4th	St	T :			21225		1.0.10			d Stat		
une	11. Marital Status	ind officering	12. Was Decedent E Armed Forces?		i. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig an, Mexican	, Puerto R	ity Yes or No- ican, etc.)	14.	Black, White	American Indian, White, etc.	
MD N/A Baltimore 10e. Street and Number 3512 4th St 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Newson Specify Cuban, Mexican, Puerto Ricar 1 Newson Specify: 1 Near or Dates: 4/86 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) 12. College (1·4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Owner										Sp	ecity: Wh	ite	
									16b. Kind	of Business/	Industry		
15. Decedent's Distal Occupation (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)										,			
E	12	oridaly (0-12)	College (1-4or 5-	+)	Bu	siness Ow	ner			C	onstru	iction	
BeC	17. Father's Name	(First, Middle, Last)					18. Mothe	r's Name	(First, Middle,	Maiden Sui	mame)	_	
70 B	David We	st Shecke	ells, Sr.				L	ouise	Jacks	on			
-		ame/Relationship (19b. Mail	ing Address (Street	and Numbe	r or Rural	Route Number	, City or To	own, State, Z	Zip Code)	
	_Rhonda I	. Sheckel	lls / wife		3512	4th St. E	altim	ore,	Mary la:	nd 21	225		
	20a. Method of Dis	•	Removal from State	20b. Pla	ace of Disp metery, cre	osition (Name of ematory or other place	ce)	Da	ite	20c. Locat	tion - City or	Town, State	
		5 Other (Specify		Bay	view	Crematory	\cdot 1	/3/06	5	Balti	more,	Marylar	ıd
	21. Signature of F	neral Service Licer	isee / / O			22. Name and Addre					_		
1	MU	MACX	WXXV			328 Sulph						cyalnd 2	1227
	23a. Part1. Enter t shock, or hea	the disease, or com art failure. List only	plications that caused one cause on each lin	the death.	Do not er	nter the mode of dyir	ng, such as o	cardiac or	respiratory arr	est, and nat	rcotic	Approximate Interval Betw	veen
1	disease or condition	(Final	a Contraction	TI	PH	euril.			cation		. 33213	Onset and D	eath
	resulting in death)		Due to (or as a	consequ	ence of):	6							
١.	Sequentially list co	enditions,	b										
lne	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Diseese or injury												
хап	that initiated event resulting in death)	S	c Due to (or as a	conseque	ence of):								_
鱼田田			240 10 (0. 43 0	· consoqui	51100 OI).								
lan/Medical Examiner	d.												
×	IF FEMALE: 23b. Was deceden	ot proposat	23c. If yes, outcome of	of pregnan	ю					23d	l. Date of deli	of delivery	
4.5	in the past 12	months?	1☐Live birth : 4☐Pregnant at			□Ectopic pregnanc; □ Other (specify) _	1				Month		ear
Completed by Physic	9 Unknown		9□ Unknown										
Y P	Part II. Other signi	ficant conditions	ontributing to death bu	it not resul	lting in the	underlying cause giv	en in Part I.		23e. Did to	bacco use	contribute to	the cause of de	ath?
ba	Chifme.	acol	Hi.	story	of Hep	atitis			1 🗆 Y	es 2 N	lo 3□Pr	obably 4 U	nknown
plet									24a. Was a	ın 2	4b. Were au	topsy findings a	vailable
E									autops	med? 2 No	death?	topsy findings a completion of ca	use of
10 25. Was case referred to medical 26 Place of Death (Check only o										70.03	2010		
2	examiner?] No	Hospital: 1 X Inpatier	nt 2 🗆 E	R/Outpatie	ent 3 DOA	er: 4 🗆 Nui	rsing Hom	e 5 ☐ Reside	ence 6	Other (Spec	cify)	
Ę	27. Manner of Dea	th 5 Pending	28a. Date of Injur (Month, Day	Year)	28b. Time Injury	of 28c. Injus Woo	y at k?	28	3d. Describe h	w injury o	ccurred		
atte	2 ☐ Accident	investigation	,,	5 .	12:00		Yes 2X∏1	vo u	ndetermiı	ned			
Certification;	3 Suicide 4 Homicide	6 XX Could not b determined	building etc	ry - At hor . (Specify)	me, farm, s	treet, factory, office	28f. Location (Street and Number or Rural Route Numb City or Town, State) 533 E. Patapsco A			er. Ave.			
Residence Baltimore, MD													
Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
ĕ.	29b. Signature and	title of certifier	312			29c. Licens	e number		2	9d. Date si	igned (Monti	h, Day, Year)	
January 01,										2006			
	30. Name and add	ress of person who	completed cause	ath (Ite	3a) (Type		• 11 • 12 •			anual	Ly OI,	2000	
		LE Mile	1,000			Penn Stre	et, Ba	altim	ore, Ma	arylar	nd 212	01	
tate	31. Date filed (Mor		32 Registra	r's Signati		•0 -	-						
trar	J	AN 0 4 20	05	e B	A	8,462							

7. Age (In yrs. last birthday)

Certificate of Death

4b. City, Town, or Location of Death

BALTIMORE

State of Maryland / Department of Health and Mental Hygiene 1

Year

2006

N/A

Race - American Indian, Black, White, etc.

Specify:

Elkride, MD

23d. Date of delivery

Month

White

4c. County of Death

2nd

3. Time of Death

9. Birthplace (State or Foreign

Washington DC

10d, Inside City Limits

UNKNOWN

UNKHOWN

UNKNOWH

UN KNOWN

Year

4 Unknown

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No

2 No

3 Probably

1 ☐ Yes X ☐ No

02:48AM

2. Date of Death

Month

JANVARY

Physician /Medical **Examiner**

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

Richard M. Sigwald

4a. Fecility Name (If not institution, give street and number)

SAINT AGNES HEALTH (ARE

1 M 2 □ F

Funeral Director

: After this certifical funeral director, I Division To the Hospital or Attending death. hours after death uneral Director: / ily filled in by the f within 24 hours a To the Funeral I

29b. Signature And title of certifier 31. Date liled (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Medical

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 Pending investigation

6 Could not be

determined

32. Registrar's Signature

Injury

28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dev. Year) 29c. License number

18611

900 CATON AVE.,

1 ☐ Yes 2 ☐ No

JANUARY 2nd, 2006

BALTIHORE 21229

281. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARHONKA MAGDALENA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1, pen#1, 0852, 2,2706 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death George Sturgeon Month **Physician** Year 4:54 AM JANUARY 2006 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs.

Solution of Birth (Month, Day, Year)

Min. Month, Day, Year) AGNES HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Yrs. Director 82 217 25 0305 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic evant, the Madical Examiner must be notified at 10d. Inside City Limits Director 1 7 Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 494 Ave tte 31398 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No N → Y Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: À Specify: 3 Widowed 4 Delvorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) th s 1 and 2 should be filed w Health and Mental Hygier tam 27 is marked other th Machinist Machiner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VIA Be ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If Itam 27 is Lisa Bodick 20b. Place of Disposition (Name of cemetery, crematory or other place) aregiver Catorsville, MD othar a1998 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ö rematory! 4 □ Donation = 5 □ Other (Specify) etro LaHO, MIL 606 21. Signature of Funeral Service Licensee 22. Name and Address / Facility 1232 Midvalley Dr. Jessof 1PA 18434 wood 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician SEPSIS day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PUTUMONIA 3 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner ician and burial-transit The law requires that the death certificate be executed Cause (Cisease or injust that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE 981 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo Month 4☐ Pregnant at time of death Day Year 5 Other (specify) P.O. detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by ACLITE RENAL FAILURE 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CURONARY AKTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate Vital 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Tyes 2 ₹ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ot this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Division or Attanding 1 Natural 5 Pending death. investigation 1 TYes 2 No 2 Accident after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the within 2 To the comple 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 18614 maria Carmila n. Bosalis. JANHARY 1, 2006

Registrar
DHMH 17 Rev 1/2001

State

201

AGNES HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Redistrar's Signature

MAYCIA CARCHELA N KOSALES,

JAN 0 4 2006

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.00

			1 - For Stete Registrar	State of M	Ce	rtificate of L			eg. No.	l b	00141
*	Physici	an	1. Decedent's Name (First, Middle, I	_{.ası)} nomas Seid	۵۱			2. Date of Deat Month January	Day 20	Year	3. Time of Death
Ç.	/Medic Examir		4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death	Januar y	4c. County		10:50 a [™]
			3660 Double F			Parkvil]			Balti	more	
1	Funeral Director		5. Social Security Number 216-34-8005 Usual Residence of Decedent	Sex 7. Ag 1 2 M 2 □ F	ge (In yrs. last birthday 68 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth Month, Say, May	1937	9. Birthp	place (State or Foreign 77 and
	yland sow		10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
	8a-1 et	ctor	Md. Baltin	nore	Cockeys	ville			1 ☐ Yes 2 ☐ No		
	ath with th	ral Dire	10e. Street and Number 1 Beehive Place	ce Apt. 1		10f. Zip Code 21030	21030			What Coun	ntry?
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, If a Mudical Examinatment the notified at once.	l by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces 1	Ever in U.S. 13.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 💆 No Specify:			Specify Yes or No- rto Rican, etc.) 14. Race Black Specify:		
5-0	"natu	leted	15. Decedent's (Specify only highest of	Education grade completed)	(Give	dent's Usual Occupa kind of work done di	uring most of worki	ng	16b. Kind of B	usiness/Ind	dustry
12	within iene. than tre Ma	Completed	Elementary/Secondary (0-12)	College (1-4or +4	5+)	DO NOT use relired) nistrator		9	State 0	f Mar	ryland
<u>p</u>	al Hyg I other	Be C	17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, N	Maiden Suman	10)	
Za	ould b Ments varked	To	Meyer Seidel					Riley			
Mar	d 2 sh th and th and 17 is m traum		19a. Informant's Name/Relationship Mrs. Terry Colel			ng Address <i>(Street al</i> 51 Rivervi			-	-	
Baltimore,	ages 1 an ent of Heal at: If Item 2 y or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control	☐Removal from State	20b. Place of Disp	osition (Name of matory or other place Of Faith (, [Date 2	20c. Location -	City or To	own, State
Baltir	permit. F Departme Importer any Injur		21. Signature of Funeral Service Lice		2	2. Name and Address 1050 York	soffacilityuner K Rd. Tow				
68760,	Physician / Medical Examiner as the purial-transit as the purial-	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of):	nc Re	ectal	Cas	rces		Onset and Death H YEARS
.O. Box	Physicien: The law requires that the death certificat this certificate has been signed by the attending phyral director, page 2 should be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Dat	e of delive	ory Day Year
rds, P	quires tha an signed uld be de	ed by P	Part II. Other significant conditions Rency	contributing to death t	out not resulting in the u	inderlying cause give	n in Part I.	23e. Did tob			ne cause of death? ably 4 Unknown
II Record	The law re cate has bee page 2 sho	Completed by						24a. Was an autopsy perform	ned?	prior to con death?	psy findings available inpletion of cause of 212 No
Vita	sicien: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Otho	26. Place of Death				HUME OF
Division of Vital	ding h. Aftel fune	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju	ent 2 ER/Outpatie ury 28b. Time of Injury	of 28c. Injury Work	4 🗀 Nursing Hor	me 5 ☐ Resider 28d. Describe how	nce 6 (2)Othow	er <i>(Specit</i> y ed	DMPANION
Divis	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Certification:	3 ☐ Suicide 6 ☐ Could not determine	286. Place of in	jury - At home, farm, st ic. (Specify)	reet, factory, office	:	28f. Location (Str. City or Town,		er or Rurai	l Route Number,
	To the Hospital or within 24 hours affer To the Funeral Dir completely filled in I	edical	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physicien: To the best aminer: On the basis of and manner st	if examination and/or in	h occurred at the time evestigation, in my opi	e, date and place, a nion, death occurre	and due to the ca ed at the time, da	use(s) and ma ite and place, a	nner as stand due to	ated. the cause(s)
)	To the I within 2 To the I complet	Σ	29b. Signature and title of certifier	u Clai	allry 1	1D 29c. License	number 406		od. Date signed		Day, Year)
	10		30. Name and address of person wh	o completed cause of c	death (Item 23a) (Type	Srint) Je 20 20000000000000000000000000000000000	S MD	21204			
	Sta Registr	7.7	31. Date filed (Month, Day, Year) JAN 0 1 2	And And And And And And And And And And	ar's Signature	A. A.					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death

4b. City, Town, or Location of Death

Glen Burnie

2. Date of Death

January

3. Time of Death

1:00 P M

2006

4c. County of Deeth

Anne Arundel

29d. Date signed (Month, Day, Year) January 6, 2005

the esn

ō

page 2

completely filled in by the

within 24 hours a To the Funeral I

Certific

29b. Signature and title of certifier

Daljeet Sidhu, M.D.,

29a. Certifier

MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Decedent's Name (First, Middle, Last)

4e. Fecility Name (If not institution, give street and number)

Mariner Health at North Arundel

R. Larry Thomas

Physician

/Medical

Examiner

Funeral Director

	5. Social Security Number	6. Sex	7. Age (In yrs. la:	ot hirthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	, 1	9 Birtholage (State or Foreign	70		
	234-62-8472	1⊠M 2□F	65	Yrs.	Months Days	Hours Min.	Nov. 25	, 1940	9. Birthplace (State or Foreig Country) West Virginia			
	Usual Residence of Decedent									Т		
	10a. State 10b. County	у	10c. City,	Town or Loca	ation				10d. Inside City Limits	s		
ţō	Maryland Anne	Arunde1	G1en	Burni	e				1 ☐ Yes 2 🖾 No	0		
9	10e. Street and Number				10f. Zip Code		1	l0g. Citizen of W	hat Country?	_		
ā	109 Second Ave	s S			21061			United S				
era.			dest Ever in II C	12 14		liange in Origin 2 (S			- American Indian,			
ŭ	11. Marital Status	Armed For			Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puerl	o Rican, etc.)		c, White, etc.			
To Be Completed by Funeral Director	1 ☐ Never Married 2(3) Mai 3 ☐ Widowed 4 ☐ Divorce	If Yes, Giv	9	1	☐ Yes 2 No	Specify:		Specify	White			
leted	15. Deceder (Specify only higher	nt's Education est grade completed)		16a. Decede	ant's Usual Occup	ation during most of world)	rking	16b. Kind of Bu	siness/Industry			
omp	Elementary/Secondary (0-12)	College (1 4	-4or 5+)		al Engin			Techno	ology			
S	17. Father's Name (First, Middle	9)	_									
O B	Roy O. Thomas											
	19a. Informant's Name/Relation	ship (Type, Print)							y or Town, State, Zip Code)			
	Ann S. Thomas / Wife 109 Second Ave., S, Glen Burnie, Marylan											
		20a. Method of Disposition 1 Bright 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State Catonsville, Maryland										
	21. Signature of Funeral Service		. I .	Ki	Name and Addre rkley-Ru 1 Crain	ddick Fu	neral Ho E., Glen	me, P.A Burnie	, MD 21061			
	23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that c	aused the death.						Approximate Interval Between			
	Immediate Cause (Final disease or condition resulting in death) a. Autt Augul tollier											
	resulting in death)											
ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a conseque	ence of):								
min	cause. Enter Underlying Cause (Disease or injury that initiated events	1	C.									
Exa	resulting in death) Last	Due to (or as a conseque									
Ical		d						_				
Jed	IF FEMALE:				-					_		
2	23b. Was decedent pregnant	23c. If yes, out	come of pregnan		Ectopic pregnanc	,			e of delivery			
<u>c</u>	in the past 12 months?		ant at time of dea		Other (specify) _	<i>'</i>		Moi	nth Day Year			
ysi	9 Unknown	9□ Unkno	own									
/ P	Part II. Other significent condit	tions contributing to de	eath but not resul	ting in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use conti	ibute to the cause of death?			
d b	Corenery ax	Peru des	Pate				1 🗆 Y	es 2 No	3 Probably 4 Unknow	m		
lete		7					24a. Was	an 24b. \	Vere autopsy findings availab	le		
Completed by Physician/Medical Examiner							autop	rmed?	orior to completion of cause of leath? Yes 2 No	ĺ.		
e C	25. Was case referred to medic	cal				26 Place of De	ath (Check only or					
To Be	examiner? 1 Yes 2 No	examiner?										
n: T	27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. Inju		28d. Describe h					
tification:		stigation	th, Day Year)	Injury		rk? Yes 2 □No						
3 Suicide 4 Homicide 6 Could not be determined 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Place of Injury - At home, farm, street, factory, office City or Town, State)									er or Rural Route Number,			

31. Date filed (Month, Day, Year) 32. Registrar's Signature South

1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1413 Annapolis Rd., #106, Odenton, Maryland 21113

D38958

DHMH 17 Rev 1/2001

State

Registrar

		Sta	or Print in Bi te of Maryland				=		00113
		1 - State Registrar	io oi marytana		tificate of l			g. No.	00190
Physicia	an	1. Decedent's Name (First, Middle, Last)	vol				2. Date of Death Month	Day Year	3. Time of Death
/Medic Examin	al	Charles A. Tre	xel nd number)		4b. City, Town, or	Location of Death	January	4c. County of Dea	ath
	_	0001	ospital			MOPE If Under 24 Hrs.	O Date of Birth	NA	that contains
Funeral Director		5. Social Security Number 204–16–5289 6. Sex 1 💆 M 2 (77. Age (In yrs. Ia 79	St Diπnday) Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day, JAN 14	1926	rthplace (State or Foreign ountry) PA
ryland how		10a. State 10b. County		Town or Loc					10d. Inside City Limits
the Ma	ecto	MD N/A	Balı	timore	10f. Zip Code		10	og. Citizen of What C	1 X Yes 2 □ No
h with t	ai Dir	4700 Harford Road			212:	14		USA	outiny.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, I're Marical Exam natural be notified a sone.	by Funeral Director	1 X Never Married 2 Married 1 H	s Decedent Ever in U.S ned Forces?]Yes 2 XNo es, Give ar or Dates:		/as Decedent of H Yes, specify Cuba ☐ Yes 2 ☑ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
within 72 hounded	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0·12) Col	leted)	(Give k	O NOT use retired	during most of work	king	Gb. Kind of Business	,
uld be fited v fental Hygie rked other t tic event, tt	To Be Co	17. Father's Name (First, Middle, Last) Herman Austin	Trexel	Baaca		18. Mother's Nam Edna	Florence	faiden Surname)	<u> </u>
2 should have and have reuman	1 :3	19a. Informant's Name/Relationship (Type, Pri						City or Town, State, MD 212	
Health tem 27 other tr		James R. Cook, III -	20b. Pia	ace of Dispos	ition (Name of atory or other place			20c. Location - City o	
Pages nent of (ant: If Its ury or o		1 ☐ Burial 2 🖾 Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)			e Cremat		2006	Beltsvill	e, MD
permit. Departr Importe any inje		21. Signature of Funeral Service Licensee	M0098	36 S	Name and Address AFA, Ste 717'Gree	ss of Facility phen D. I n Pasture	ohrmann, s Drive;	PA Towson,	MD 21286
Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	that caused the death. In on each line. A raia C Fa Due to (or as a consequence to (or a))).	ilure ence of): Nal		ig, such as cardiac		st,	Approximate Interval Between Onset and Death
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edicai Examine	Cause (Disease or injury that initiated events c.	Due to (or as a conseque	ence of):					
the death certi y the attending sched for use a	Physician/Medical	in the past 12 months?	es, outcome of pregnan]Live birth 2	déath 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year
w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contribution Chronic Obstructi			derlying cause giv	_	23e. Did tob	. /	to the cause of death? Probably 4 □Unknown
sician: The law re certificate has be- irector, page 2 sho	Completed	Diabetes		,			24a. Was ar autops perform 1 Tes 2	prior to death?	autopsy findings available completion of cause of s 2 \square No
/sician s certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospita	l: 1 1 Inpatient 2 E	R/Outpatient	3 DOA Oth	or	th (Check only one ome 5 Aeside	nce 6 □Other (Sp.	ecify)
To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director, I	ation: T	27. Man⊓ f of Death 1 ✓ Naturaf 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Injur Wor		28d. Describe ho		
ef or Atte s after de el Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e	. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Str City or Town	reet and Number or F , State)	Rural Route Number,
Mospit 24 hour Funer letely fills	Medical (29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: O ar	To the best of my known the basis of examination manner stated.	vledge, death on and/or inv	occurred at the tir estigation, in my o	me, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner a ate and place, and du	is stated. ie to the cause(s)
Vithir To th	ž	29b. Signature and title of certifier			29c. Licens	e number	29	od. Date signed (Mor	nth, Day, Year)
, 1		30. Name and address of person who complete	MD M Cause of death (Item	23a) (Tvna 1	Print)	2000	ν,	anuary	09,2006
4		Srilatha Kanumui	rump 5	601	Loch .	Kaven 1	3/Vd, Be	altimore	03,2006 MD 21239
Sta Registr		JAN 0 6 2006	32 Registrar's Signat	ure A	ede				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>006</u> **Physician** Month Year Georgie Myrtle Tomlin Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genisis Elder Care -Dundalk Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□ Director 219-30-7284 87 Feb. 16, 1918 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic evant, the Medical Examiner must be notified at MD Baltimore Middle River 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 12 Right Wing Drive 21220 USA permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or name any injury or other traumatic even. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify:White Completed by 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) own home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Lipscomb Cora Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley J. Biggerman 5354 King Arthur Circle Baltimore Md21237 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardensof Faith 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1/9/06 Rossville MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 MAce Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner TION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed CEREBROVASCE of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy performed 1 ☐ Yes 2 No 2 No fo the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes Medical Certification: To 2 000 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Accident within 24 hours after death

To the Funeral Diractor;
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mindu le completed cause of death (Item 23a) (Type, Print) 2 Masker 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of I	Maryland		artment			and M	ental Hy	giene	IIII	001	45
K.	* ************************************		1. Decedent's Name (First, Middle, La	st)					-		2. Date of De Month			3. Time of	Death
	Physici: /Medic			elia K.	Tracy		r				Januar	y 1,		7:00	Рм
	Examin	er	4a. Facility Name (If not institution, give						Location of	of Death			County of Dea		
45 N	F	16.	Montgomery Gener 5. Social Security Number 6. Social Security Number		Age (In yrs. las	t birthday)	If Under	lney	If Under	24 Hrs.	8. Date of Bir	th.	ontgome	theless (Ctob)	r Fornian
	Funeral Director			1□M 2 X F	90	Yrs.	Months	Days	Hours	Min.	(Month, Da November	22, Year)	1915 Con	necticu	t Turaign
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Farra and a									
	fanyla f shov	ō												10d. fnside C	-
	the h	Directo	Maryland Montgom 10e. Street and Number	ery	3110	ver 5	pring 10f. Zip	Code				10a. Cit	lizen of What Co		
	h with	O I	15551 Prince Fre	derick Wa	ay			2090	6			_	ted Sta	•	
	deat	ner	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S.	13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	>-	14. Race - Ame Black, Whit		
36	or it	by Funeral	1 Never Married 2 Married	1 Tes 2	XNo		1 □ Yes 2		Specify:		, , , , , , , , , , , , , , , , , , , ,		Specify: W		
Ö	hour	ed b	3 Widowed 4 Divorced	Year or Date		16a Dece	dent's Usua	I Occupa	ation			16b K	ind of Business		
Maryland 21215-0036	hin 72 a. In "na Wedis	Completed	(Specify only highest gr Elementary/Secondary (0-12)			(Give life.	kind of wor DO NOT us	k done d e retired,	luring mos	t of workii	ng	100.10	and or business	/ industry	
2	ed wit	Con	12			Homem	aker					Own	Home		
and	be file	Be	17. Father's Name (First, Middle, Las	•							(First, Middle				
3	hould d Mer marke	임	Frederick Malvic 19a. Informant's Name/Relationship			10b Maili	an Addraga	(Street o			te Pla		or Town, State,	7:- 01 \ 0.0	006
∑ S	id 2 s Ith an 27 in r	Ì	Benjamin E. Tracy										r Sprin		
re,	item		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Nam	ne of		D	ate		ocation - City or	-	
Ē	Page nent c ant: if ary or		1 ☐ Burial 2 MCremation 3 [4 ☐ Donation 5 ☐ Other (Speci		169		Cremato		, I O	anua 200	ry 4,	Beth	nesda, N	Marylano	d
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinant must be multiped at once.		21. Signature of Funeral Service-Lice	nsee	M01305	Rố 30	bert A. 0 West	Addres Puni Monts	phrey gomery	Funera Aven	al Home/ ue, Rock	Rocky ville	ville, Inc e, Marylar	nd 20850-	2805
) (2) (2)			23a. Part1. Enter the disease, or con shock, or heart failure. List only	npfications that cau	sed the death.	Do not ent	er the mode	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximat fnterval Bet	e ween
	Physician		fmmediate Cause (Final disease or condition	a AtH	EROSCI	leroti	i 6	ARDI	oras	cula	- DIS	EAS	SE	Onset and	Death
4	/Medical Examiner		resulting in death)		as a conseque			· -							
1		ē	Sequentially list conditions, if any, leading to immediate	b Due to (or	as a consequer	nce of):			_	_					
	uted d ansit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
Ó	an an	Exa	resulting in death) Last	Due to (or	as a conseque	nce of):									
8760,	icate be executed physician and s the burial-transIt	dlcal		_ d											
9	eath certific attending p	/Med	IF FEMALE:	23c. If yes, outco	me of pregnanc	v									
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Ö.	that the death ted by the atter detached for u	hys	9 Unknown	9□ Unknow	n			,,							
S, P	res tha igned be del	by Physician/Me	Part II. Other significant conditions	contributing to deat	th but not resulti	ng in the u	nderlying ca	ause give	n in Part I		23e. Did t	obacco	use contribute to	1	leath?
ord	w requir been si should	ted									1 🗆	Yes 2	□No 3□Pi	robably 4	Inknown
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				I Oth		of Death	Check only	one)			
	hys this al dii	. To	1 Yes 2 No 27. Manner of Death	1 Inp		VOutpatier 8b. Time o			4 140	- 1	ne 5 Resi 28d. Describe		6 Other (Spe	icify)	
ion	Attending r death. ector: After by the funer	atlor	1 Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	м	8c. Injury Work	(?` ∕es 2 🗆		200. 00001100	now inju	ry occurred		
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٥	Hospital or 14 hours afte Funeral Dir tely filled in I												,		
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edical	29a. Certifier 1 Certifying P (Check only one)	hysician: To the be miner. On the basi and manne	is of examination	edge, deat n and/or in	h occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s date and) and manner as d place, and due	s stated. to the cause(s)
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	10		JOHN HERRING	m)	arms 1	3a) (Type, RING	Print) EPHI	LIP	DR	0	LNEY	M	MARY (1) 20 (832	
Mark Comment	Sta Registi		31. Date filed (Month, Day, Year)	2008 P	skar's Signatur		poste	7)			, , , ,		
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		For State Registrar	State of Marylan		ificate of			eg. No.	00146
Physic	an	1. Decedent's Name (First, Middle, Last)		7.7			2. Date of Deat Month	h Day Yea	3. Time of Death
/Medi	cal	Cornell 4a. Facility Name (If not institution, give str	Raeford T		4h City Town	or Location of Deat	Jameny	4c. County of De	~
Exami	ier	Baltimore VA	1 / / //	nter	Ba	1+iniore		N/A	•
uneral irector		212 00 3000	7. Age (In yrs.	ast birthday)39 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, May 28,	^{9. 8} 1966 Mai	Sirthplace (State or Foreign Country) ryland
Mou		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loca	ation				10d. Inside City Limits
important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be multified at <u>once.</u>	ctor	Maryland N/A			Ba	1timore			1 Yes 2 □ No
ZI AN	Dire	10e. Street and Number			10f. Zip Code	21.6	1	0g. Citizen of What	Country?
CTIER	neral	3204 Westwood Ave	. Was Decedent Ever in U.	.S. 13. W	as Decedent of	∠ ⊥	pecify Yes or No-		mencan Indian,
	d by Funeral Director	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 12 Yes 2 No If Yes, Give Year or Dates: 1980	11	Yes, specify Cub ☐ Yes 2 (XNo		to Rican, etc.)	Specify:	Black
	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Decede (Give ki	nt's Usual Occu ind of work done O NOT use retire	pation during most of world)	rking	16b. Kind of Busines	ss/Industry
	от	Elementary/Secondary (0-12)	College (1-4or 5+)		ctory W	-		Facto	ry
	Be	17. Father's Name (First, Middle, Last)			· -	18. Mother's Nar	me (First, Middle, M	Maiden Sumame)	
	J.	Jack Jones 19a. Informant's Name/Relationship (Type	(Drint)	10h Mailing	Address /Street	1.	atrice Ta		- Ti- Code)
r trau		Beatrice L. Mason/M		1				. City or Town, State ore, MD 21	
any injury or othe QDCB.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Rer	noval from State	Place of Disposi emetery, crema	tion (Name of atory or other pla	ace)	Date	20c. Location - City	or Town, State
		* 4 □ Donation 5 □ Other (Specify)	Me			Inc. 1/5		Baltimor	e, MD
9000		21. Signature Funeral Service Licensee Fdward A. Grego	rchik	22.	299 Fre	^{ess of Facility} Cr derick Ro	remation and Balt	Society o imore, MD	f MD, Inc.
٦		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	tions that caused the deat	·					Approximate Interval Between
an		Immediate Cause (Final disease or condition	Rund S	Failure					Onset and Death
al er		resulting in death)	Due to (or as a conseq	uence of):					1 1
	Jer	Sequentially list conditions, b.	Due to Gray a conseq	uence of):					IWIC
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e as trie Dunal-transit	Medicai	IF FEMALE:	I for a subsequence of a second						
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De detached for use	by Ph	Part II. Other significant conditions contr	-	ulting in the und	derlying cause gr	ven in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
spould		End-Stage AID	5				1 🗆 Ye	s 2□No 3 X	Probably 4 Unknown
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director, page	Be C	25. Was case referred to medical examiner?					ath (Check only on		
	-To	1 ☐ Yes 2 🕅 No Ho 27. Magner of Death	spital: 1 X Inpatient 2 28a. Date of Injury	ER/Outpatient 28b. Time of	3U DOA		-	ence 6 Other (S)	pecify)
	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Inju Wo M 1	ork?]Yes 2 □No	28d. Describe no	w injury occurred	
	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (St City or Town		Rural Route Number,
completely tilled in by the tune	edicai (29a. Certifier 1 X Certifying Physic (Check only one)	cian: To the best of my known: On the basis of examination and manner stated.	wledge, death ition and/or inve	occurred at the t estigation, in my	ime, date and place opinion, death occu	a, and due to the caurred at the time, di	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
сош	M	29b. Signature and title of certifier				se number		9d. Date signed (Mo	
`			, D.		(19613	1	amony "	t. 200b
1		30. Name and a dress of N rs in who com	pleted cause of death (Item	n 23a) (Type, P	rint)	10	N. G1	reene St	treet Bultimore, Md
	ate	31. Date filed (Month, Day, Year)	32. Panatrar's Signa		0				
egis	•	JAN 0 6 20	06 pleases.	B A	الألا				
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician A Elia MOMPSON 2606 Anuary /Medical 4c. County of Death Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAILIMORE Joseph Kirto 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🗷 F 218-58-8476 Yrs. DETAWARE Director Anuary Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County Baltimore 10d. Inside City Limits or 28a-f show or other traumatic event, the Middical Examiner must be notified at 1 Xes 2 No Director KANDAllstown HARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Circle 3633 Shire USA or itams 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: 3 ₩Widowed 4 Divorced FRICAN HMERICAN 'naturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) l and 2 should be filed within lealth and Mental Hygiene. om 27 is marked other than ". Elementary/Secondary (0-12) College (1-4or 5+) 1244 NURSE 11 th tospita6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ames CANNON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other trau Circle. Verby Shire 500) KANDA 115-town Md-21244 OllAnd-Theodore 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ring Memorial OC 4 □ Donation 5 □ Other (Specify) Loodawn Tark 22. Name and Address of Facility
NANCH M. WHITELE 21. Signature of Funeral Service Licenses FUNERAL SCRUIS St. BAltimore MARYland 21229 3405 W. FRANKLE 20 Enter redisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) uturive cervical cA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit Due to (or as a consequence of): ician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4☐ Pregnant at time of death 5 Other (specify) detached Physi 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð been si 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical. director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 Z No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 ANatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the sausa(s) and man as sausated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and a dress of

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** O3 01 2006 Thompson 3:30a.M Sallie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Manor Care Nursing Home Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Hours | Min. | 01 | 07 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 GA **Funeral** Year) 1 ☐ M 2 🛱 F Yrs 83 Director 253-38-7803 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-fahow r than "natural", or itema 23a or 28a-f ahov the Madical Examinar must be notified at 1 Yes 2 □ No Director Baltimore MD NA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21216 U.S.A. Funeral 3218 Mondawmin Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ Black 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Seamtress Loudon Fog 10th grade Pages 1 and 2 should be filed v timent of Health and Mental Hygie tant: If itam 27 is marked other taury or other traumatic avent, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lula Holbrook Tom Holbrook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3218 Mondawmin Ave, Baltimore, Md 21216 William Holbrook-Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Dogation 5 ☐ Other (Specify) 1/7/06 Loudon Park Baltimore, Md 21. Signiture of Funeral Service Ligensee 22. Name and Address of Facility
March F/H West . Thempan e me 21215 4300 Wabash Ave, Baltimore, 23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Attends clerch C Condition and Condition resulting in death) Approximate Interval Between Onset and Death **Physician** 3 Yust /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine signed by the ettending physicien end d be detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown been si should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s 1 ☐ Yes 2 € No 1 Yes 2 No of Vital aral Diractor: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after To the Hospitel o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 mion D31865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gutam street mian-0 Rm 206 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2120 San Select Registrar JAN 0 5

			1 - For State Registrar	State of Mai	ryland /		rtment of H		d Mental	Hygier	W 0 0 0	00149
			1. Decedent's Name (First, Middle, Las	it)					2. Date	of Death		3. Time of Death
П	Physici		Clauda &	ugene	Too	11			Month		Day Year 3 2006	- 645 AM
	/Medic		4a. Fecility Name (If not institution, give		101	14	4b. City, Town, o	r Location of D			4c. County of Death	
	Examin	er		1	/ /		Salia	h			Wicomi	
			John B Parsons F 5. Social Security Number 6. S	5515401	(In yrs. last b	idhday)	If Under 1 Year	If Under R4 I	Hrs. 8. Date of	of Birth		C C place (State or Foreign
	Funeral		1	M 2□F	92	Yrs.	Months Days		Ain. (Monti	h, Day, Yei	ar) Cou	intry)
	Director		244-05-0036 Usual Residence of Decedent		92				Apr	16,19	913 AL	
	and		10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Aary sho	ō	MD Wicomic		Mare	do 1 a	Springs					1 ☐ Yes 2 ☑ No
	he N	ect	10e. Street and Number	0	Male	цета	10f. Zip Code			100	Citizen of What Cou	
	vith to	Ö	10e. Street and Number							109.	Citizen of what Cot	antry r
	ath v	rai	7560 Todd Lane				21837				J.S.A.	
	e de de	une	11. Marital Status	 Was Decedent Ev Armed Forces? 		13. V	Vas Decedent of H Yes, specify Cub	ispanic Origin's an, Mexican, Pi	(Specify Yes ouerto Rican, etc.	or No- :.)	14. Race - Amer Black, White	
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show he Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give)	1	☐ Yes 2X No	Specify:			Specify: Wh:	ite
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Maryland 21215-0036	al H	Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, M.	iddle, Maid	len Sumame)	
<u>Ja</u>	Mend	٩	James Thomas Tod	d				Thic1	a Isado	ra Du	ırrah	
an	and smu	. 4	19a. Informant's Name/Relationship (Гуре, Print)	19	b. Mailin	g Address (Street	and Number or	Rural Route N	umber, Cit	ty or Town, State, Zi	p Code)
Σ	1 and 2 Health em 27 I		Mr Lowell H. Tod	d Sr. Sor	ı i	7560	Todd La	ne Mard	ella Sp	rings	, MD 2183	37 - 2464
re	ges 1 and 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-f show or other treumatic event, the Medical Examiner must be routined at	1 1	20a. Method of Disposition				sition (Name of natory or other plan	ce) -	Date		Location - City or T	own, State
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Baltimore,	nit. Fartment ortar	1	21. Signature Tuperal Sevice Liger		oodal		. Name and Addre	on of English		-		
Ba	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.	ļ, ļ	pall Ele		1120		Second A	venue S	Singlet SW Glen	on Fu Burn	neral Homie, MD. 2	e. P.A. 1061
	1 - 9		23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused t	he death. Do	not ente	er the mode of dyir	ng, such as care	diac or respirate	ory arrest,		Approximate Interval Between
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- Alle	Examiner			500 10 (0) 43 4	consoquence	0 017.						
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8760,	cate be executed physician and the burial-transit	dical		d								
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Division of	ttandi death. ctor: A / the fu	at	2 ☐ Accident investigation				M 1 🗆	Yes 2 □ No				
<u>\forall '\forall or Attandater deatl	ŧΪ	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, stre	et, factory, office			ion (Street r Town, St	and Number or Rui	al Route Number,	
	s after s after al Dire	Certification;	- 4								,	
	e Hospital 24 hours a e Funaral letely filled		29a. Certifier 1 Certifying Ph	ysicien: To the best of	my knowled	ge, death	occurred at the til	me, date and pl	ace, and due to	the cause	e(s) and manner as	stated.
	To the Hospital or Attanwithin 24 hours after death. To the Funaral Director:	edical	one) 2 Medical Example one)	and manner state	ed.	יותו זים/טרווא	estigation, in my u	philon, death o	ccurred at the t	ime, gate a	and place, and due	to the cause(s)
	To the within 2. To the I complet	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. I	Date signed (Month,	Day, Year)
	C > F 0		> whinch	DR. INC	Im No	Uniti	tri Dos	7250		Ja	n 3rd x	005
	10		30. Name and address of person who			-		133/		300		
	10							1//				
			31. Date filed (Month, Day, Year)	32 Registrar		- У	717 718	7				
	Sta Registi		JAN 0 5 200		#	1	A.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registramend Item #4a Per PHY C851 1 Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JOSEPHINE JANUARY TODES 7:45 2006 /Medical 4a. Facility Name (If not institution, give street and number)

COPPER RIDGE NURING HOMES 4b. City, Town, or Location of Death 4c. County of Death Examiner SYKESVILLE CARROLL Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 6. Sex Min. Days Months Hours 1□M 2∏F Director 207-14-2453 80 12/17/1925 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No **Funeral Director** MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? filed within 72 hours after death with ō 1 POMONA EAST APT. or items 23e 506 21208 U.S.A. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: Black, White, etc. WHITE 1 Never Married 2 Married 3altimore, Maryland 21215-0036 þ Specify 3 ¥ Widowed 4 □ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: if item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 5+ SOCIAL WORKER STATE OF MARYLAND 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MORRIS ROSENTHAL **JEANNETTE** ANGEL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5961 SETTER DRIVE - ELKRIDGE, MD 21075 ROBERT TODES / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) ö Department of Importent: if eny injury or once. BETH EL MEMORIAL PARK 01/04/2006 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician lementia lears /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (clisters of light) Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Cause (Cisease or triju that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. by Physiclan/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2□ No 1 ☐ Yes 2 No or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ao Medical Certification: To in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation after death. 1 Tes 2 No 2 Accident Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 [3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a To the Funerei L o the Hospitel completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Stone

DHMH 17 Rev 1/2001

State Registrar filed (Month, Day, Year)

32. Registrar's Signature

		Pleas	se Type or Pri					-		_	
		1 - For State Registrar	State of M	laryland		irtment of H <i>tificate of L</i>		nd Mental Hy	ygien Reg. W	HHb	00151
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/Medic			Charles		der,	Sr.		01-02-	-06		9:15 A
Examine	er	4a. Facility Name (If not institution				4b. City, Town, or		Death	40	CECIL	th
		VA MARYLAND HE 5. Social Security Number		YSTEM ge (In yrs. la	ast hirthday)	PERRY If Under 1 Year	POINT If Under 24	Hrs. 8 Date of B	idh		tholase (State on Fourier
Funeral Director		213-32-0605 Usual Residence of Decedent	№ м 2□ F	69	Yrs.	Months Days		Min. 8. Date of B (Month, D Apr 30	(19)	36 Mar	thplace (State or Foreign ountry) yland
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "neturel", or items 23a or 28e-f show eumatic event. It a Madical Exterinate must be inclined at	tor	Md. 10b. County	timore		, Town or Lo Dunda						10d. Inside City Limits 1 Tyes XIXNo
or 28e	irec	10e. Street and Number				10f. Zip Code			10g. C	tizen of What Co	ountry?
23a c	aiD	102 Patapsco	Avenue			212	22			USA	
tems erm	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S	S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin In, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race · Ame Black, Whit	
s afte	by F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Yes Give			☐Yes 2√ No	Specify:			Specify:	
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hin 72	pie	(Specify only highes Elementary/Secondary (0-12)	st grade completed) College (1-4or	.5+)	(Give life. L	kind of work done of OO NOT use retired	during most o	f working			
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narke	င္	John Tuder, 19a. Informant's Name/Relationsh		000)	105 14-75	A 11 (7)	Edna	Marie		hiermy	
permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "neturel", or items any injury or other treumatic event. It a Medical Exerting mages.		Margaret Demb				g Address (Street a Patapsc		or Rural Route Num. e . Dunda l			
Heal Heal tem 2	3	20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of	1	Date	1	ocation - City or	
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partm partm sorte / inju		21. Signature of Funeral Service I		11100							1 Home, PA
permi Depa Impo any ii	10	Tout & Por	Dars								d. 21222
Pnysician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each	IIIO. IEGATI	VE SEP	TICEMIA	g, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death UNKNOWN
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hysic his ce I direc	2	examiner? 1 ☐ Yes 2 🎇 No	Hospital: 1 Knpat	ient 2 🗆 E	ER/Outpatien	t 3□ DOA Othe	er: 4 🗋 Nursi	ing Home 5 Res	idence	6 ☐Other (Spe	cify)
ding Physician: The n. n. After this certificate ha funeral director, page	on:	27. Manner of Death 1 X Natural 5 ☐ Pending		jury ay Year)	28b. Time of Injury	28c. Injury Work	(?	28d. Describe	how inju	ry occurred	
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alor A s after al Dire	Certification;	4 Homicide determi	building, e	etc. (Specify))	set, factory, office		City or To	wn, State	9)	inas moditė rvantibėr,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	edical (29a. Certifier 1X Certifyin (Check only cne) 2 Medical I	ng Physician: To the bes Examiner: On the basis and manyers	of examinati	vledge, death ion and/or inv	occurred at the time restigation, in my op	e, date and pointon, death	place, and due to the occurred at the time	cause(s , date an) and manner as d place, and due	stated. to the cause(s)
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6+1		30. Name and address of person				*	ספי פעפר	יחסיום א שוו	י סס	LVIO WID	21902
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 1, 2006 January 5:00P M GRIER CORBIN TAYLOR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 323 Taplow Road Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Yrs. 215-50-3789 58 November 12,1947 Maryland Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla actment of Health and Mental Hygiene. crtant: if Item 27 is marked other than "natural", or items 23a or 28a-f show njury or other traumatic event. The Medical Examples count by notfled at XXX es 2□No Funeral Director Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21212 USA 323 Taplow Road 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes Art No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Mever Married 2 Married 1 Tes XXX White Baltimore, Maryland 21215-0036 ģ Specify 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Vocalist Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Corbin Taylor Catherine Griesemer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Knoll Ridge Court #1621 Baltimore, Maryland 21210 William Corbin Taylor Brother 20a. Method of Disposition
1 □ Burial AMCremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State GreenMount Cemetery 1/4/06 Baltimore, Maryland □ Donation 5 □ Other (Specify) permit.
Departr
Imports
any nju signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 2 No 2 1 Tes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Peath 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After Injury 5 Pending М 1 Yes 2 No death. Accident investigation the Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 | Homicide within 24 hours after To the Funeral Dire To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

NWV



us ni ause of death (Item 23a) (Type, Print) 29c. License number

29d. Date signed (Month, Day, Year) January 3, 2006

State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 💍 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** January Thomas Volatile 2006 07:05a^M Michael /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 19, 1925 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1₩ 2□F 218-18-4888 80 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b Count or 28a-f show 7 is marked other than "natural", or items 23s or 28s-f ebov traumatic event, tre Modical Exercinar must be notified at 1 ☐ Yes 2 No Baltimore Director Marvland Towson 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 607 W. Chesapeake Ave. 21204 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WUII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify. Specify: White ģ 3 ☐ Widowed 4 🏋 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Dentist Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Theresa Scarantino Anthony Volatile 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: if item 27 is eny injury or other trat once: 2421 Cub Hill Road Paul Clemmitt / Friend Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/6/06 Arlington, Virginia Arlington National Cem. 21. Signature of Funeral Service License 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 10 months Cancer /Medical Due to (or as a con sequence of): Examiner Sequentially list conditions, Tany leading to mediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consiquence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tas 2 No 3 □ Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed certificate 1 Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how intury occurred 1 Natural 5 Pending 1 Yes 2 No death. ours after death. neral Director: A filled in by the fu 2 Accident 6 ☐ Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral 6 Medical 29a. Certifie Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ner stated. (Check only one) 29b. Signatura and atle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 231) 10+1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of M	laryland		artment tificate			and Me	ental Hy	giene Reg. No.	006	0015) L;
	Dhisiai		1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	aath Day	Year	3. Time of D)eath
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y = 8*,	Funeral Director		5. Social Security Number 212-46-8497 Usual Residence of Decedent	5. Sex 7. A	ge (In yrs. Ia: 58	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da Dec. 2	ay, Year)	G	thplace (State or ountry) ryland	roreign
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	o within 72 hours after beath with the marylan siene. Jene. Then Thatural', or items 23s or 28s-f show then Modical Examinat mast be inclined at	by Funerai	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces	? No		Was Decede f Yes, specif		spanic Origin, Mexican Specify:	gin? (Spec	cify Yes or No lican, etc.)		4. Race - Am Black, Whi Specify:		
9500-612	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	5+)	(Give	dent's Usual kind of work DO NOT use	done d	uring most	t of workin	g		d of Business		
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Mary	s 1 and 2 should f Health and Men. Item 27 le marke. Other traumatic		19a. Informant's Name/Relationshi		ıghter		ng Address (Chris				Route Numb			_	
٠,	of Health of Health Item 27 I	L,	Mrs. Cathie L.		1 000	ce of Dispo	sition (Name	e of			ate		ation - City or	Town, State	
ב ב	m = = =		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		9		of Fai			1/5/	2006	Bal	timore	, Maryla	and
Baitimore,	permit. Pag Depertment Important: any injury once.		21. Signature of Funeral Service Li	censee	2	22	. Name and	Addres	s of Facility	ty	ome of	Dur	dalk, and 2	Inc. 1222	
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	ate be executed hysicien end the burial-transit	ical Examin	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	s a conseque										
	attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetat o	death 3]Ectopic pre] Other (spe					2.	3d. Date of de Month	,	ear
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	rtifice ctor. p	BeC	25. Was case referred to medicat examiner?	VIVII LUC	20114				26. Place	of Death	(Check only				
ō	his d	2	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, D	ient 2 🗆 E ury ay Year)	R/Outpatier 28b. Time of Injury		c. Injury Work	at ?	2	e 5 Res 8d. Describe		Other (Spe	ecify)	
$\bar{\bar{z}}$	el or Attending P s after death. Il Director: After I d in by the funera	Certification:	2 Accident investigated a Suicide 6 Could not determined.	28e. Place of II	njury - At hom atc. (Specify)	ne, farm, str			/es 2 □ l	2.		(Street and wn, State)	Number or R	lural Route Numb) 0 /,
	Hospite 4 hours Funera tely fille	Medical C	29a. Certifier 1 ☑ Certifying (Check only 2 ☐ Madical E	Physician: To the bes xaminar: On the basis and manner s	of examination	rledge, death on and/or in	h occurred a vestigation, i	it the tim	e, date an pinion, dea	id place, ai	nd due to the d at the time,	cause(s) a date and	and manner a place, and du	s stated. e to the cause(s)	
:	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c.	License	number			29d. Date	signed (Mon	th, Day, Year)	
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	17		30. Name and address of person w												
	10		DEVI SENGUPTA: 4					LTI	MURI	E, M	D 212	24			
The second	Sta Registi	ate rar	31. Date filed (Month, Pay, Year)	005 Regis	trar's Signatu	Joe Soc	de								

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State of Maryland / Department	artment of Health and N rtificate of Death		ene 2006	00155
	Physici	an	Decedent's Name (First, Middle, Last) CNAMBLIT A ANN VIET THE C		2. Date of Death Month	3, 2006 Year	3. Time of Death
	/Medic	al	CYNTHIA ANN VELINES 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JANUARI	4c. County of De	
	Examin	ler	12 CEDARHILL RD.	RANDALLSTOWN		BALTIMO	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 217–54–2387 1 M 2 F 53 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 3-14-19	Year) 9. Bi	rthplace (State or Foreign Country) ORTH CAROLINA
	Director		Usual Residence of Decedent		3-14-19	932 NC	ORTH CAROLINA
	arylan show	_	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits 1 X Yes 2 ☐ No
	the M	Director	MD BALTIMORE RANDALLS 10e. Street and Number	TOWN 10f. Zip Code	10	og. Citizen of What C	
	h with		12 CEDARHILL RD.	21133		USA	outroy.
36	filed within 72 hours after death with the Maryland Hygiene. other then "neturel", or Hems 23s or 28e-f show ent, If a Modical Examiner must be medified at	by Funeral	1 Never Married 2 Married 1 Yes 2 LNo	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh Specify: BI	ite, etc.
Maryland 21215-0036	72 hou	eted	15. Decedent's Education 16a. Dece	dent's Usual Occupation	una 1	6b. Kind of Busines	s/Industry
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ylan	should be filed ind Mental Hygi marked other umatic event, I	To B	WILLIAM J. MORRIS	ANNIE W	ILLIAMS		
Mar	12 sho h and 7 is ma ireum			ing Address (Street and Number or Run			
	s 1 and f Healt item 2 other 1		20a Method of Disposition 20b, Place of Dispo	GRANTLEY AVE BAI		MARYLAND Oc. Location - City o	
altimore,	m O		1 A Burial 2 2 Cremation 3 Hemoval from State	CEMETERY 1-6-2	2006 в	ALTIMORE,	MARYLAND
Balti	permit. Page Department Important: if any injury o			R Name and Address of Facility PHI $721-27$ N. MONROE S			
			23a. Pant Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		or respiratory arre	st,	Approximate Interval Between Onset and Death
,	Pnysician /Medical	H	Immediate Cause (Final disease or condition resulting in death)	Scletosis			15 years
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rds, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.			o the cause of death?
I Records,		Completed			24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Vital	stcien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Othor	h (Check only one)	
o	y Phys er this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	of 28c. Injury at	me 5 Resider 28d. Describe hov	nce 6 Other (Spe w injury occurred	ecify)
ion	anding sath. or: Afte	atlo	1 ⊠Natural 5 □ Pending (Month, Ďaý Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of	or Attuiter de Directuin by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, stubullding, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or F State)	lural Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certification and a second that the funder of the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place.	and due to the car	use(s) and manner a	s stated.
	n 24 h he Fui pletely	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in	ivestigation, in my opinion, death occurr	red at the time, dat	te and place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and tytle of certifier	29c. License number	29	d. Date signed (Mon	th, Day, Year)
•	2	15	30. Name and address of persen who completed caus	Print) /	Jo	arwary &	1 200
_	0	8	Robert Mmkley MD 516 N.	Rolling Road Sui	re zoy	Caronso	le Maryland
ě	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 6 2006 Registrar's Signature	29c. License number D 25 2 7 4 Print) Roding Road Sui			, ,

		1	For State Registrar	State of	Marylan		artment of H	ealth and M Death	ental Hygie	C 0 0	6	00156
			1. Decedent's Name (First, Middle, L						2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		Bernice Van	desrift					01	01	2005	1:15 A-M
	Examin		4a. Facility Name (If not institution, g					Location of Death		4c. County		
			Mound County					ia, Maryland		Hon	wd Cour	1
	Funeral Director		5. Social Security Number 6. 237–28–3739	Sex 7 1 ☐ M 2 🖫 F	'. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You April 19		9. Birthp Coun Delar	lace (State or Foreign try)
			Usual Residence of Decedent					1	Whill 12	, 1717	Detai	ware
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
:	e Ma	cto	Maryland How	ward			Columbia	1				1 ☐ Yes 21 No
	다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다	Director	10e. Street and Number				10f. Zip Code		10g	. Citizen of \	What Coun	itry?
	23a		6260 Dawn Day				2104				S.A.	
	e de de de de de de de de de de de de de	Funerai	11. Marital Status	12. Was Deced	ces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe In, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ ck, White,	
တ္ဆ	or li	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give	,		1 ☐ Yes 2 🙀 No	Specify:		Specify	V: T.71	
3	hour turai	d be		Year or Dat	tes: 	160 Dagg	dont's Havel Ossus	ation	100	b Kind of B		hite
င်	n 72	Completed	15. Decedent's (Specify only highest g	rade completed)		(Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of worki f)	ing 16	b. Kind of B	usiness/inc	iustry
7	than ene.	шc	Elementary/Secondary (0-12)	College (1-	4or 5+)		Homemaker			C	own Ho	OMA.
2	Hyg Hyg other ent,		17. Father's Name (First, Middle, Las	st)		1			(First, Middle, Ma			Sinc
Baltimore, Maryland 21215-0036	ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Of Health and Mental Hygiene. The marked other than "natural; or items 23s or 28s-f show frother traumatic event, Ite Marsical Examinar must be notified at	To Be	Ralph Pierce					Helen M	Meredith			
<u></u>	shound M	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	and Number or Rura		ity or Town,	State, Zip	Code)
Š	nd 2 alth a 27 is rtrau		Pierce Vandegri	ft (son))	6260	Dawn Day	Drive C	Columbia.	Maryl	and 2	21045
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Ē	permit. Pages 1 Department of H important: If ite any injury or ott once.		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		tate	-		ery 1-7-2	2006 Wi	1mines	ton.	Delaware
<u>=</u>	mit.	1	21. Signature of Funeral Service Lic	ensee	117,11	22	Name and Addres	ss of Facility				
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	/Medical		resulting in death)	Due to (c	or as a conseq	uence of):	INS TO THO	my Diseas	C			
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g	quire in sig uld bi								1 🗌 Yes	2 🗆 No	3 Prob	ably 4 Unknown
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<u>+</u>	Physician: this certific al director.	10	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗐	patient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing Ho	me 5 Residenc	e 6 Oth	ner (Specify	v)
0 0	Attending Ph er death. ector: After th by the funeral		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date o (Month	f Injury n, Day Year)	28b. Time o Injury	f 28c. Injur Wor		28d. Describe how	injury occur	red	
Sio	eath. or: A the fu	cati	2 Accident investigat 3 Suicide 6 Could not				M 1	Yes 2□No				
Division of	or Att	ertification;	4 Homicide determine	28e. Place	of Injury - At h ig, etc. <i>(Specii</i>	ome, farm, str fy)	reet, factory, office		28f. Location (Stree City or Town, 3		per or Rura	I Route Number,
_	pitel purs g eral I	O	29a. Certifier 1 Certifying	Physician: To the	heet of my kno	wledge deat	h occurred at the tir	ne, date and place,	and due to the seve	20/0) and m	20001 00 00	ento d
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical		aminer: On the ba and mann	sis of examina	ation and/or in	vestigation, in my o	pinion, death occurr	ed at the time, date	and place,	and due to	the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier		_		29c. Licens			. Date signe		
i			Illian !	Eun M.	D.		0	006365	3	1/03	1200	6
	6		30. Name and address of person who Shaun Eur	io completed cause	of death (Iter	п 23а) (Туре,	Print)	006365 lumbia, Ma	syland 210)44		
	e Sta	ate	31. Date filed (Month, Day, Year)		egistrar's Signa				-			
	Regist		JAN 0 5 2	F.	Azer &	y As	8 26 das					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 2, 2006 **Physician** Mary Irene Wernick 9:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1716 Hilltop Road Baltimore Essex 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2878F 219-12-9549 Director Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1716 Hilltop Road 21221 U.S.A. by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ¥ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "na any injury or other traumatic avant any once." Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Kurowski Laura Gos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Wernick (Daughter-in-Law) 4 Brown Cone Garth, Nottingham, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Aurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of JesusJan. 5,2006 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between shock or heart failu Immediate Cause (Final disease or condition resulting in death) Obstructive Pulmonary Viscase **Physician** hroniz 10 year /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy ó in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tulmonary Nodules 1 Yes 2 No 3 Probably 4 Unknown Breast Mass 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has all director, page 2 autopsy performed? (es 2.2 No restension 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification; To funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident I Director: A d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral C 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 t 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO057721 MU eath (Hem 23a) (Type, Print)
ESSEX Medical Center Bottimore, MD 21221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laura L. Steple 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 9,19a per fh 8851 I-5-06 vt. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Sofin WatKins 0 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner NIA Itospital Baltimore Union Memorial If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 214.40.8815 Months Days Hours Min 1 M 2 K 63 Yrs. NC Director 05.13. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f ahow r than "natural", or iteme 23a or 28a-f ahov the Medical Examinar must be notified at MD Baltimore 1 MYes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 602 Bart 21218 Avenue USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) St. Joseph Hospital Dietician 10th grade 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tent: If item 27 is marked ot Be C. Randle, 8r. Crettie Mock James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 si Department of Health ar importent: if item 27 is any injury or other treu once. Jesse F. Watkins Baltimore MD 21218 602 Bartlett Avenue Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion 01.10.06 Bultimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 2. Nam. an Address of Eachlity
Limits 1000 Francisco Service
114-121 S. Stricker street Baltimore MD 21223 A.G. 23a. Part1. Enter the diselve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Seb Immediate Cause (Final disease or condition resulting in death) nset and Death Physician monte /Medical Due to (or as a consequence of): Examiner 85 Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner transit The law requires that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-t Division of Vital Records, P.O. Box 68760. Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 20/No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: Other: 1 🔲 Yes ၉ 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Inpatient 3 DOA 28 Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural
2 Accident Injury 5 Pending death. 1 Yes 2 No investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide hours after within 24 hours a 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca (Check only one) ş 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D05505 Dr Zhang, Rong, 3333 N. Co 31. Date filed (Month, Day, 32 Segistrar's Signature State Registrar

			For State Registrar	State of Ma		epartmei Certifica			d Menta	al Hygie Reg.	F C C C	00159
· .	»		Decedent's Name (First, Middle, Last)							ite of Death	Day Year	3. Time of Death
	Physicia /Medic	al	CIFI	IAMS						wasy (3, 2006	0455 AM
	Examin	er	4a. Facility Name (If not institution, give stre		A			Location of D			4c. County of Deat	
4 1 m		, ~ <u>~</u>	5. Social Security Number 6. Sex		(In yrs. last birth		4271~	If Under 24	MS. I A Da	te of Birth		hplace (State or Foreign
	Funeral Director			1 2□ F	67 Y	Months	Days		Vin. (M	onth, Day, Ye	ar) Co	Cennessee
47	ס		Usual Residence of Decedent						journ	uui y 2	.,,1750	
	arylar ehow	_	Maryland N/A		10c. City, Town	or Location timore						10d. Inside City Limits XXYes 2 ☐ No
	28a-f	Director	Maryland N/A 10e. Street and Number		Бат		p Code			100	Citizen of What Co	
	be filed within 72 hours after death with the Maryland the tygene. A least of other then "naturel", or items 23a or 28a-f show do ther then "naturel", or items 23a or 28a-f show event, 11a Medical Exacticat must be retilied at	٥		Apt. 9		101. 2	p Code	21211		109.	Onizen of What Co	USA
	death	Funeral	11. Marital Status 12	. Was Decedent Ev	ver in U.S.	13. Was Deci	dent of Hi	spanic Origin	? (Specify Y	es or No-	14. Race - Ame	
٥	or its	Fu	1 Never Married 2011 Married	Armed Forces? 1 ☐ Yes 2 X XNo If Yes, Give	,	1 ☐ Yes		n, Mexican, Pa Specify:	ueno rican,	etc.)	Black, White	_{e, etc.} √hite
0030	hours after ture!', or its	d by	3 Widowed 4 Divorced	Year or Dates:								
212	within 72 ene. then "nat	lete	15. Decedent's Educa (Specify only highest grade of	completed)		Decedent's Usi Give kind of w life. DO NOT	ork done d	lurina most of	working	160	. Kind of Business/	Industry
7 7	r ther	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	')	Bolie	er Mal	ker		В	ethlehem	Stee1
and	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle, Last)								den Sumame)	
>		P	Dewey Williams				Į	····		nstaff.		
Mar	12 should h and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type Barbara Williams	(Wife)		Mailing Addres 01 Fa1			r Rural Rout t. 9	_	ty or Town, State, 2 more, MD	Zip Code) 21211
	s 1 and of Healt item 2 other	- 1	20a. Method of Disposition		20b. Place of I	Disposition (Na	me of		Date	_	Location - City or	
<u> </u>			1 ☐ Burial 2X XCremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Metro	, <i>crematory</i> `cr Cremat.c			/2005	Ca	tonsville	e, Maryland
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature Inneral Service Libense		1	22 Name a	nd Addres	s of Facility				
מ	Ped in the part of		munt (arpente		Burge 3631	Hen.	ss-Sei -Road	tz Fun Balti	eral H	ome, Inc. Maryland	21211
			23a. Parti. Enter the disease, or complica shock, or heart failure. List only one	tions that caused to cause on each line	he death. Do no	ot enter the mo	de of dying	g, such as car	rdiac or resp	iratory arrest,	riar y rana	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CONGRE	TIVE F	1 EARL?	FAIL	wie				Onset and Death
	/Medical Examiner		resulting in death)	A .	consequence of	•	10	PMC1	t to od			
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of	cara, A		7777-21				
$\sqrt{}$	outed id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
Ď,	be executed ician and burial-transit	Exe	resulting in death) Last	Due to (or as a	consequence of	·):						
9/8 19/8	cate be executed physician and the burial-transit	dical	d.			_						
×		/Me	IF FEMALE: 230	: If yes, outcome o	of pregnancy						80 1 8 1 1 1	
ROX	atten atten	cian	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death	3 ☐Ectopic 5 ☐ Other (s					23d. Date of del Month	Day Year
o.	it the death certifi by the attending I tached for use as	Physician/Me	1 Yes 2 No 9 Unknown	9□ Unknown								
ດ໌ ລັ	res that igned to be det	by P	Part II. Dther significant conditions contri	buting to death but	t not resulting in	the underlying	cause give	en in Part I.	2	3e. Did tobac	co use contribute lo	the cause of death?
ord	w require been sign	ted								1 Tes	2 □ No 3 □ Pr	obably 4 Unknown
Records,	a taw r	Completed							_ 2	4a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u> </u>									1	performed □Yes 2☑	death? No 1 ☐ Yes	210 No
Vita	sician	Be C	25. Was case referred to medical examiner?	spital:	, DET. 10		Othe	26. Place of			. 70:: .:	
ō	Physer this eral di	n: To	27. Manner of Death	1 ☐ Inpatien	28b. Ti		28c. Injury Work	4 1401311			e 6 Other (Spe	cify)
0	Attending P death. ctor: After y the funera	atlo	2 Accident S Pending investigation	(Month, Day	rear) In	jury M		<br Yes 2 □ No				
Division of	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injurbuilding, etc.	ry · At home, far	m, street, facto	ry, office			ocation (Stree	t and Number or Ri	ural Route Number,
	urs aff											
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) Cartifying Physic 2 Medical Examine	cian: To the best of or: On the basis of and manner stat	examination and	death occurre /or investigation	d at the tim n, in my op	ne, date and p pinion, death o	olace, and du occurred at t	ie to the caus he time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
	To th withir To th comp	Ň	29b. Signature and title of certifier			2	9c. License			29d.	Date signed (Mont	h, Day, Year)
)			1				05	1715			1/3	06
	6		30. Name and address of person who com				16/10	34	71M0/	K M	o viv	()
6	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra								-
4	Regist	ar	IAN 0 5 201	16	A. A.	Post	A.					

ORIGINAL

			For State Registrar	State of Ma	ryland /		artment of F		nd Mental Hy	gieni Reg. No	UUU.	001	60
	Physicia	217	1. Decedent's Name (First, Middle, La	*					2. Date of De. _Month	Da	ay Year	3. Time of	Death
	/Medic		John Franci						Januar	y 3	, 2006	3:30	Рм
	Examin	er	4a. Facility Name (If not institution, giv				4b. City, Town, o		Death	40	County of Death		
	F		3537 Keswick Road 5. Social Security Number 6.5		(In yrs. last b	irthday)	Balti If Under 1 Year		Hrs. 8. Date of Birt	h	N/A	place (State o	r Foreign
L	Funeral Director		219-30-0631	M 2□F	71	Yrs.	Months Days	Hours	Min. (Month, Da Sept 9,	y, Year	Cou	yland	
	ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Lo	cation					10d. Inside Ci	ty Limits
	a-feh	ctor	Maryland N	/A]	Baltimore	2				X ₩Yes	2 □ No
	with the	Funeral Director	10e. Street and Number 3537 Keswick Road				10f. Zip Code	2121		10g. Ci	itizen of What Cou	ntry? SA	
	death	nera	11. Marital Status	12. Was Decedent 8 Armed Forces?	ver in U.S.	13. \	Vas Decedent of H		n? (Specify Yes or No Puerto Rican, etc.)	.	14. Race - Ameri	can Indian,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or Items 23e or 28a-f show entry injury or other traumatic event, the Medical Evant and the rolllind at once.	by	1 Never Married XX Married 3 Widowed 4 Divorced	1 Tes 2/2/2/N If Yes, Give Year or Dates:	lo		Yes 2XX No	Specify:	Puerto Hican, etc.)		Black, White, Specify: wh:		
15-(n 72 h "natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	166	(Give	lent's Usual Occup kind of work done OO NOT use retired	during most o	of working	16b. H	Kind of Business/In	idustry	
212	l within iene. r than	omo	Elementary/Secondary (0-12)	College (1-4or 5	+)		house wo	,		D	istiller	v	
br	e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last					18. Mother's	s Name (First, Middle,	Maide	n Sumame)	,	
<u>ylar</u>	Mente Rarked arked	To	John Elwood Wa:	rd					len G. Pat				
Mar	nd 2 shoulth and 27 le m		19a. Informant's Name/Relationship (Elizabeth Ward	Type, Print) (Wife)			g Address <i>(Street</i> Keswick		or Rural Route Numbe Baltimore,				
Baltimore,	of Heal		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other place	-	Date		ocation - City or To		
<u><u>Ë</u></u>	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 🖾 Wither (Special	Masoleum				· 1	06/2006	Pil	kesville,	Mary]	Land
3alt	permit. Departi Import. eny inj		21. Signat Funeral Service kies	nsee	1	B11	Name and Addre	ss of Facility	tz Funeral				
	403 8 Q		23a. Part 1. Enter the disease, or com	- Chepen	the death Do	36	31 Falls	Road	tz Funeral Baltimore	, M€	$\frac{1}{1}$	21211 Approximate	
	Discontinuo		23a. Part I. Enter the disease, or comshock, or heart failure. List only	A 1.	1 1 .	THOI GITE	1 1		irdiac or respiratory ar	rest,		Interval Bet Onset and I	ween
	Physician / /Medical		disease or condition resulting in death)	a. Mycca	consequence	100:	tarction	1					
В	Examiner		Sequentially list conditions	b		, .							
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	consequence	of):							
	xecution and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequence	e of):							
8760,	cate be executed physician and the burial-transit	dicai E	(d									
Box 6	death certific e attending p id for use as f		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						I	23d. Date of delive	ary	
.O. B	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 4□Pregnant at 9□Unknown			Ectopic pregnancy Other (specify)	<u>'</u>			Month	Day Y	'ear
σ.	requires that the de een signed by the s hould be detached f	by Ph	Part II. Dther significant conditions	contributing to death bu	ıt not resulting	in the ur	nderfying cause giv	en in Part I.	23e. Did to	bacco	use contribute to t	he cause of d	eath?
rds	w requires been sign should be		Hypertensic	50					1 🗆 Y	es 2	. □ No 3 □ Prot	bably 4 🔀	nknown
Vital Records,	law as b 2 sl	ompieted	Diabetes	Mellitus					24a. Was		24b. Were auto	psy findings a	available
Ä	Th ate pag	Com							perfo	med?	death?	2□ No	ause or
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	0.5	f Death (Check only o				
of	Phyer this ral dir	: To	1 ☐ Yes 2 ☐ Mo 27. Manner of Death	1 Inpatie		utpatien Time of	t 3☐ DOA Oth	4 [] Nursi	ing Home 5 Resid			ý)	
ion	Attending Phire death. ector: After this by the funeral	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Injury	Wor	k? Yes 2 □ No		.011 11110	ny oodan og		
Division	i Site	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	iry - At home, t :. (Specify)	farm, str	eet, factory, office		28f. Location (S City or Tox		nd Number or Rure e)	al Route Numi	ber,
	Hospitel 24 hours a Funerel 6 etely filled	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysicien: To the best of miner: On the basis of and manner sta	examination a	ge, death ind/or inv	occurred at the tir	me, date and p pinion, death	place, and due to the o	cause(s date an	s) and manner as s d place, and due to	tated. the cause(s))
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	~			29c. Licens	e number		29d. Da	ate signed (Month,	Day, Year)	
			1 Sulsy a	. Jay "	10			3221		- 1	14/06		
	10		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type,	Baltin	nore, Y	landand	21	24		
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ır's Signature			1.	U		·		
Uh	Registr MH 17 Rev 1/2		JAN 0	5 2006	Charles A	Ja .	france			-			
J.1	17 1167 1/2			all a		IGINA	L						

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Doris K. Williams 1, 2006 January 2130 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center for Hospice Care Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐ XF Yrs. Director 219-18-5070 21, 1925 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Extrainer must be notified at Md. 1 Yes 2 No Completed by Funeral Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6451 N. Charles Street 21212 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Stalus 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) real estate agent real estate 12 years . Pages 1 and 2 should be lifed viment of Health and Mental Hygie tant: If Item 27 is marked other jury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John C. Kelly Gertrude McNaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick C. Williams, Jr./son 2811 Elliott Street, Baltimore, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Parkwood Cemetery 1/6/2006 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. Duai a Willen 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Belween Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End-Stage dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ⋈ No 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification; 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 125205 JANUAY 2, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5% Balto md 6701 Charles 37 Registrar's Signature 31. Date filed (Month, Day, Year) JAN 0 4 2006 Registrar

Villiams, Moris

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 11 16 2

	1	For State Registrar	State of Mary		partment of F prtificate of i			eg. No.	16 (10162
Physicia		Decedent's Name (First, Middle, Last,	Walte				2. Date of Dea Month	Day	Year 2006	3. Time of Death 8 457M
/Medic Examin	_	4a. Facility Name (If not institution, give			4b. City, Town, o	Location of Death		4c. County		
	8	3102 CORNWall	Rd.	f a facial de	v) If Under 1 Year	A/K If Under 24 Hrs.	O Date of Birth		MORE	
Funeral Director		216-13 6011 /	M 2□F	yrs. last birthda	Months Days	Hours Min.	8. Date of Birth (Month, Day	8,1924	9. Bittiple Countr	(State or Foreign
aryland show	}	Usuel Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location				10	d. Inside City Limits
a-f sh	ctor	MD Balti	more	Dun	dalk					1 □Yes 2 ☐ No
with the	Funeral Director	10e. Street and Number	wall Ro	/	10f. Zip Code		1	log. Citizen of V	What Countr	ry?
ne 23	erai	3/02 CORA	12. Was Decedent Ever		2 / 2 3. Was Decedent of H If Yes, specify Cuba		pecify Yes or No-		e - America	n Indian,
ie, with yield X 12 15 15 15 15 15 15 15 15 15 15 15 15 15	þ	1 Never Married 2 Married 3 Never Married 4 Divorced	Armed Forces? 1		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Rican, etc.)		ck, White, et	
72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Gi	cedent's Usual Occup ve kind of work done	during most of work	king	16b. Kind of Bu	usin <i>es</i> s/Indu	ustry
within lene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ille.	Rafe C	Llerk	,	MTHC.	CIVIL	SCRVICE
lal y allo 2 12 2 should be filed with and Mental Hygiene. Is marked other that aumatic event, Item	Be C	17. Father's Name (First, Middle, Last)			7 - 2 - 3	18. Mother's Nam	ne (First, Middle,	Maiden Suman		
should b	To	William					lice K			
Mand d 2 sh th and th and traum traum		19a. Informant's Name/Relationship (T)	rpe, Print) SON	19b. Ma	illing Address (Street	and Number or Ru	ral Route Numbe L	r, City or Town,	1177	Code)
is 1 and of Health itam 27 other tr		20a. Method of Disposition	2	20b. Place of Dis	position (Name of rematory or other place	ce)	Date	20c. Location -	· City of Tow	vn, Stete
Pages ment of land: If its ury or o		1 Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)		1	Forest	1/4	106 1	DWINGS/	4.15	NO
paritinoie, permit. Pages 1 an Department of Heall Important: If itam 2 any injury or other one.		21. Signature of Funeral Service Licens			22 Name and Addre	ss of Facility I - A Sh ton Willow.	Funera	1 Stor	7e, P.	A.
- Br - Sa		23a. Pert1. Enter the disease, or comp	M0/455 lications that caused the		enter the mode of dyir	ng, such as cardiac	or respiratory are	rest,		Approximate Interval Between
Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	4	erolial	in faretion	^			_ (Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):	15-	V211				
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	nsequence of):	ry diseous	?			-	
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cate be executed physician and sthe burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):						
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ath certi	M/us	23b. was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		3 □Ectopic pregnanci	v			ite of deliver	
- 9 9 D	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at tim 9☐ Unknown		5 Other (specify)	, 		Mo	onth C	Day Year
RECORDS, P.O. The law requires that the tee has been signed by the bage 2 should be detache		Part II. Other significant conditions co	ntributing to death but n	ot resulting in the	underlying cause gr	ren in Part I.	23e. Did to	bacco use cont	tribute to the	e cause of death?
VICAL MECOLOS, ician: The law requires i certificate has been signs rector, page 2 should be.	ed by						1 🗆 Y	es 2 🖾 No	3 🗌 Proba	ably 4 🗆 Unknown
law relas beras be	ompleted						24a. Was a	sv	prior to com	sy findings available apletion of cause of
VITAI MEC vician: The lav certificate has rector, page 2:	O						1 ☐ Yes	21 No	death?	2 No
ysician: ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpa	tient 3 DOA Ott		th (Check only or ome 5 ≥ Fesid	THE PARTY OF THE P	ner (Snecify	1
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UIVISION Of VITAI tal or Attending Physician: 7 s after death. at Director: After this certificat ad in by the funeral director, p	Certification;	4 Homicide determined	building, etc. (- At nome, tarm, Specify)	street, factory, office		28f. Location (S City or Tow		per or Hural	Houte Number,
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	edicai	29a. Certifier (Check only one) 1 ☐ Certifying the 2 ☐ Medical Example one)	iner: On the basis of ex and manner stated	amination and/o	auth command at the ti r investigation, in my o	me, date and place opinion, death occu	, and due to the t rred at the time, o	date and place,	and due to	the cause(s)
To the within To the comp	M	29b. Signature and title of certified	/	4.4.4	29c. Licens	-		29d. Date signe	id (Month, D	Day, Year)
		1910N 114	100	MS		1232		1/3/	060	
10+1		30. Name and address of person who co	A	n (Item 23a) (Ty	on, Print)	Baltima	re Mo) 212	22	
	ate	31. Date filed (Month, Day, Year)	32. Angistrar's	Signature	Road !		1			-
Regist		JAN 0 4 21	006 Street	A Ser Marie	Series Series					

State of Maryland / Department of Health and Mental Hygiene 1 1 5 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yeer **Physician** 02:00A M Mary F. Wiegel I a nugry 03 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. Sept. 19, 74) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign ^{Year)}1920 **Funeral** 1 ☐ M 2 🙀 F 212-18-5048 85 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be restilled at Baltimore 1 Ves 2 □ No Md. N/A Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21239 USA 6401 Loch Raven Blvd. Apt. 831 Pages 1 and 2 should be filed within 72 hours after death inent of Heatth and Mental Hygiene. Int: If item 27 is merked other than "naturel", or Items 23. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White δ 3 Widowed 4 □ Divorced Year or Dates: Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Money Counter 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jessie M. Day Frederick Paul Fischer ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If itsm 27 is any njury or other trau once. 1504 Gleneagle Road Baltimore, Md. 21239 Jessie W. Hilseberg/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Owings Mills, Md. Garrison Forest Cem. * 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Preumonia disease or condition resulting in death) Iweek /Medical Due to (or as a consequence of) Examiner Hypogy cemia 30 minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician Physician/Medicai as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No detached o 9 Unknown 9 Unknown signed by Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 XIm atient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending 1 Natural within 24 hours after death. To the Funeral Diractor: A investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January Allo Sugamone & MD 00063/76 3,2006 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Mwachinemere MD Union Memorial Hospital 32. Begistrar's Signature State persi Registrar IAN 0 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | | Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Year WATSON ROLAND Η. 4:20 AM JANUARY 2, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-13-1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days XX M 2 F 77 383-22-2005 Yrs. MICHIGAN Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County rthen "natural", or itame 23a or 28a-f show the Medical Examiner must be nutified at MD. BALTIMORE TOWSON 1 ☐ Yes 2√XNo Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? APT.1112 800 SOUTHERLY ROAD, 21286 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1XXYes 2 □ No KOREAN If Yes, Give WAR 1 Never Married X2X Married 1 ☐ Yes XX No WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+)
PLUS YEARS Elementary/Secondary (0-12) CORPORATE SAFETY MANAGER permit. Pages 1 and 2 should be filled v Depertment of Health and Mental Hygie. Important: if Item 27 is marked other 11 any injury or other traumatic event, Illa once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HENRY WATSON GOLDA SISSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DAVID B. WATSON (SON) 98, 12th. AVENUE, SEA CLIFF, NEW YORK, 11579 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State HILLTOP SERVICE CORP. 01-03-2006 TOWSON, MD. 21204 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 1050 YORK ROAD G. RUTH) RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BRAINSTEM CEREBROVASCULAR THROMBOSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: 1 Natural 2 ☐ Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation Director 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) led in by 4 Thomscide within 24 hours a To the Funeral L 29a, Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The lew requires that the death certificate be executed

Records, P.O. Box 68760.

Division of Vital

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year). --

29b. Signature and title of pertifier



Meglia

30. Name and Vidres of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

D 41410

29d. Date signed (Month, Qay, Year)

02

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Doris Marie Young January 4, 2006 2:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1□M 2XF 55 Director 216-54-5204 MAY 13, Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits in than "natural", or Itams 23a or 28a-f show the Modical Examiner must be notified at 1 Yes 2 No Maryland N/A Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 812 Mangold Street 21230 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill Certified Bander es 1 and 2 should be filed of Health and Mental Hygie filem 27 is marked other rother traumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis Edward Windsor Dolores Elizabeth Hall ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angel D. Heath/Daughter 1182 Washington Boulevard Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/5/06 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, 21. Signature of Funeral Service Licensee

Edward A. Gregorchik 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the dispate, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Certavasentas accident (CVA) massive Physician disease or condition resulting in death) Due to (or as a consequence of): restisa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Thknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No After this certific funeral director, 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hos 1162

/Medical Examiner physicien end s the burial-transit The law requires that the death certificate be executed Records, P.O. Box 68760 ettending pt ed by the e s certificete has t lirector, page 2 s Division of Vital

death

after death Director: d in by the

within 24 hours at To the Funeral D completely filled in

Baltimore, Maryland 21215-0036

al Hygiene.

Be ۲ Certification:

Medical

State

25. Was case referred to medical examiner? 1 Yes 2 → No 27. Manner of Death

1 Matural

2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

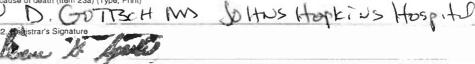
of death (Item 23a) (Type, Print)

and manner stated.

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31. Date filed (Month, Day, Year)

30. Name and addr ss of p



Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year UILLE 1521 PM January 03 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL THE JOHNS HOPKINS CITY BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2(X)F Yrs 218-46-5472 59 MD Aug. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Jacobs Lee Court 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medica1 Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Geneva Beatrice Robinson Robert Edward Boone, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Jacobs Lee Court, Reisterstown, MD 21136 Norman W. Yuille Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 1/7/06 Woodlawn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. A DENO CARCI NOMA

Due to (or as a consequence of): RI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 2 Fetal death 3 Ectopic pregnancy Dav Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 X10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, the o. ۵. Division of Vital Records, page certificete this After death. i Director: A within 24 hours after To the Funeral Dire ÷

Physician

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permit. Pages 1 and 2 should be filed within Department of Health and Mentai Hygiene Important: if Itam 27 ie marked other then "n any niury or other traumatic exceptions."

Physician

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filed within 72 hours after death

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

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Certification; To

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lankarani 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WOLFE STREET BAITIMORE MD 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature

State Registrar

JAN 0 5 2006

2006

			For State Ragistrar	State of Ma		artment of Hea		ıtal Hygier Reg. I		00167
	Physici		1. Decedent's Name (First, Middle, Las. Gloria Mar		ller			Date of Death	Day 2006 Year	3. Time of Death 8:10 P M
	/Medic Examir		4a. Facility Name (If not institution, give Stella Maris	street and number)		4b. City, Town, or Loca			4c. County of Death Baltimore	.1
	Funeral Director		5. Social Security Number 6. Se 214-14-8247	x 7. Ag	e (In yrs. last birthday, 83 Yrs.		Jnder 24 Hrs. 8. pours Min. Fe	Date of Birth	9. Birthr	place (State or Foreign Nand
poelvie	show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits
M off His	a or 28a-f De notifie	Funeral Director	Md. Baltimor 10e. Street and Number 221 Hunters		Timonium	10f. Zip Code 21093		10g. (Citizen of What Cour	1 ☐ Yes 2X No
5-0036	points: 1 agos 1 and 2 a	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Na	Was Decedent of Hispan If Yes, specify Cuban, Me	ic Origin? (Specify exican, Puerto Rica ecify:	Yes or No- n, etc.)	USA 14. Race - Americ Black, White, W	
21215-0036	iene. then "natur	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College 1-4or 5	(Give	dent's Usual Occupation kind of work done during DO NOT use retired) Maker	g most of working		Kind of Business/In	dustry
Maryland 2	Mental Hyg irked other itic event,	To Be C	17. Father's Name (First, Middle, Last) Milton J. Griffi	th		18. [Mother's Name (Fir Mary Ca			
, Mary	ealth and r		19a. Informant's Name/Relationship (7) Mr. Gerard J. Zell		usband 2	ng Address (Street a <i>nd N</i> 21 Hunters	Ridge Rd.	ute Number, City Timoni	y or Town, State, Zip UM, Md. 2.	Code) 1093
Baltimore,	tment of H tant: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Disportant Commetery, creating Hilltop	sition (Name of matory or other place) Service Co.	1-9-06		Location - City or To	
Bal	Depar Impor		21. Signature of Funeral Service Licens	99	2:	2. Name and Address of P RUCK TOWS 1050 York	Fagility Funera Rd. Tows	1 Home;	Ing ₀₄	
14.	hysician and xaminer and local as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ALZHEIM Due to (or as a b. Due to (or as a c.	ER S DISEA: a consequence of): a consequence of): a consequence of):		ch as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
I Records, P.O. Box 6. The law requires that the death certifie	ned by the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
Records, P.	been signed b should be deta	þ	Part II. Dther significent conditions co	ntributing to death bu	ut not resulting in the u	nderlying cause given in F	Part I.	23e. Did t <i>o</i> bacco	o use contribute to the	
al Rec	certificate has b irector, page 2 st	Completed						24a. Was an autopsy performed? I□ Yes 2 X N	prior to cor death?	osy findings available inpletion of cause of
of Vital	is certii directo	To Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2 ▼ No	lospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatier	0.1	Place of Death (Chi		6 XIOther (Specify	HOCDICE
Vision of	death. ctor: After th y the funeral		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	v 28b. Time of		28d. I	Describe how inj		HOSFICE
5	글들드	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, str :. (Specify)	eet, factory, office	28f. L	ocation (Street a City or Town, Sta	and Number or Rura. te)	l Route Number,
To the Hospital	in 24 hou the Funer pletely fill	Medical	29a. Certifier (Check out) one) 1 Certifying Phy Medical Exami	sician: To the best on nar: On the basis of and manner sta	examination and/or in	n occurred at the time, da vestigation, in my opinion.	te and place, and d , death occurred at	ue to the cause(the time, date ar	s) and manner as stand due to	ated. the cause(s)
Jot	To	2	29b. Signature and title of ceriffier			29c. License num	ber	29d. D	ate signed (Month, L	Day, Year)
	10		30. Name and address of person who co DR. TARIQ MAHMOOI		eath (Item 23a) (Type,		onium, md	21093	1-/	
4 A	Sta Registr	ar	31. Date filed (Month, Day, Year) JAN 0 6 20	32. segistra	r's Signature	all)				

JANUARY 4, 2005

GLORIA ZELLER

			For State Registrar	State of Marylan		artment of H rtificate of L			giene 0 0	6 00168
	Physici		1. Decedent's Name (First, Middle, Last) Laurence Kenma	r Adams				2. Date of Dea	Day	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give si	reet and number) HOSP(TAC		3. 10 (MOR	E	4c. County of	
Ž,	- Funeral Director			7. Age (In yrs. I M 2□F 89	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	Hrs. 8. Date of Birt Min. (Month, Da Aug. 1,	v, Year)	9. Birthplace (State or Foreign Country) Connecticut
	Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Howard		.Town or Lo					10d. fnside City Limits 1 ☐ Yes 2 図 No
	with the	I Director	10e. Street and Number 3370 N. Chatham R			10f. Zip Code 2104	2		10g. Citizen of W	/hat Country?
036	be filed within 72 hours after deeth with the Maryland that Hygiene. Indicate than "natural" or items 23a or 28s-f ehow event, the M-dires Examinat must be notified at	by Funeral		2. Was Decedent Ever in U. Amed Forces? 1 Mayes 2 No ff Yes, Give Year or Dates:	!			? (Specify Yes or No- uerto Rican, etc.)		e - American Indian, k, White, etc. : White
Maryland 21215-0036	e filed within 72 hoi al Hygiene. I other than "naturi vant, ire Moolen	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	during most of ()		16b. Kind of Bu	corp Corp re Gas/Elect.
land	ould be filed Mental Hygi arked other atic evant, II	To Be C	17. Father's Name (First, Middle, Last) Otis Lee Adams					Name (First, Middle, 1sta Oster		θ)
Mary	d 2 sh th and th and 7 Is m traum		19a. Informant's Name/Relationship (Type Mae A. Adams Wi					Rural Route Number D; Ellico		State, Zip Code) , MD 21042
Baltimore,	permit. Pages 1 en Department of Heal importent: If Itam 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, crer	sition (Name of matory or other place		Date 1/2006		City or Town, State
Balti	permit. I Departm importer any inju		21. Signature a Funeral Service License			. Name and Addres	ss of Facilist Home of Ondson		hton Sch	wab Witzke
	Physician /Medical Examiner	Examiner	23a. Part1. Enfer the disease of complication shock, or heart failure. (Lis) only on Immediate Cause (Final disease or condition resulting in death) a	ations that caused the death a cause on each line. DEBULT Due to (or as a consequence of the consequence o	uence of):	ATH	g, such as car	diac or respiratory ar	rest,	Approximate Interval Between Onset and Death 3-4 menths MANY YEARS COUPIC O
.O. Box 68760,	It the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Medical Exa	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a consequence of pregnance) Idea If yes, outcome of pregnance of the pregnant at time of doing of the pregnant at time of the pregnant	ncy death 3	Ectopic pregnancy			23d. Date Mon	e of delivery
Ω.	uires that the signed by Id be detact	Ď	Part II. Other significant conditions con	ributing to death but not resi	ulting in the u	nderlying cause give	en in Part I.			ibute to the cause of death? 3 ☐ Probably 4 ∰Ünknown
Vital Records,	ician: The law requires that certificete has been signed b rector, pege 2 should be deta	Completed						1 ☐ Yes	rmed? d 2 No 1	Vere aulopsy findings available trior to completion of cause of leath? ☐ Yes 2 ☐ No
	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Impatient 2 I	ER/Outpatier	nt 3 DOA Othe	ar	Death (Check only only only only only only only only		or (Specify)
ion of		atlon: T	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	/ at		now injury occurre	
Division		Certification:	3 Suicide 6 Could not be determined	28e. Pface of friury - At he building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	er or Rural Route Number,
	To the Hospitel or within 24 hours after To the Funarel Director Completely filled in E	Medical	29a. Certifier 1 V Certifying Phys (Check only 2 Medical Examinone)	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, deatl tion and/or in	n occurred at the tim vestigation, in my op	ne, date and p pinion, death o	lace, and due to the occurred at the time,	cause(s) and mai date and place, a	nner as stated. and due to the cause(s)
)	To the within 2 To the comple	2	29b. Signature and title of certifier	21/		29c. License	number 398	1	San 05	(Month, Day, Year)
	141		30. Name and address of person who con	projected cause of death (Item	23a) (Type,		MITMO	H GE	D 515	101
-8	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	Angella 1				

ARMS/LOURENCE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan. 6, **Physician** 2006 William Richard Atkinson 4:15 P. M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3470 Albantowne Way Edgewood Harford 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1ĂM 2□F Director 579-52-0135 65 Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show Maryland Harford Edgewood Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3470 Albantowne Way 21040 United States death Funeral 12. Was Decedent Ever in U.S. – Armed Forces? 1961 – 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exerci-Black, White, etc. 1 X Yes 2 No 1963 If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0wner Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Combs Atkinson Edna Mae Burnside 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Atkinson / Wife 3470 Albantowne Way Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Jan 12, Metro Crematory * 4 □ Donation 5 □ Other (Specify) Catonsville, MD 21. Signature et Funeral Service Licensee 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Ocular 16 years meta state MELGNOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, certificate be Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed Cocoun Arten 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2₩ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral (27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? After 28d. Describe how injury occurred 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD Q38409 1/9/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Falls # 415 Lumerille 7d, 21053 31. Date filed (Month, Day, Year) 32. Palistrar's Signature JAN 09 Registrar 2006

		•	For State Registrar	State of Marylan		nent of Health and cate of Death		giene 06	00170
·	- Pleasing		1. Decedent's Name (First, Middle, La	st)			2. Date of De Month	ath Day Year	3. Time of Death
	Physici /Medic		MATTIE	BYRNE			JAN	6 200	6 5:57 PM
	Examin		4a. Facility Name (If not institution, giv			City, Town, or Location of Deat	h	4c. County of Deat	
				uare Hospi	tal	Kosedale		Baltin	nore
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	Director		212 - 20 - 2865 Usual Residence of Decedent	8 8	115.		MAY 30	,1923	MS
	and and		10a. State 10b. County	10c. Cit	y, Town or Location	n			10d. Inside City Limits
	the Marylar 28e-f ehow	ō	MD N	A	B	ALTIMORE			1 Yes 2 □ No
	28e	- C	10e. Street and Number			of. Zip Code		10g. Citizen of What Co	untry?
	3a or	Funeral Director	3129 Che	sley Ave.		21734	1	U.S.A	
	ter death w	ner	11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was I	Decedent of Hispanic Origin? (S , specify Cuban, Mexican, Puer	pecify Yes or No		rican Indian,
9	or its		1 Never Married 2 Married	Armed Forces?			to Alcan, etc.)		e, etc.
5-0036	72 hours after death with the Maryland natural', or iteme 23a or 28e-f ehow iteal Examiran must be inclined at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		es 20 No Specify:		Specify: Lu	hite.
	"natural",	Completed	15. Decedent's E (Specify only highest gra		(Give kind	Usual Occupation of work done during most of wo	rking	16b. Kind of Business/	Industry
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2	lled y		17. Father's Name (First, Middle, Last	NIA,	[-]	one MAKER	ma /First Middle	, Maiden Sumame)	
anc	ntal h	Be					GERBIC		
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	to 1 and 27 tem 27 other tr		20a. Method of Disposition	20b. F	Place of Disposition	(Name of	Date	20c. Location - City or	
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量	permit. Pages Department of Important: If I any injury or once.		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		clens of	me and Address of Facility <-	100	DH (10-1-10	
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¢			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the deat one cause on each line.					Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a conseq	quence of):				
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	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	quence or):	+/ - 5			
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687	certificate Iding phys			_ d					
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	death e atten ed for u	lcla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Feta 4□Pregnant at time of d		opic pregnancy er (s <i>pecify)</i>		Month	Day Year
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	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions	contributing to death but not res	sulting in the under	ying cause given in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Ď	w require been sig should b	ed					10	Yes 212 No 3 ☐ Pr	obably 4 Unknown
တ္တ	2 0 0	plet					24a. Was		topsy findings available
Ä	0 5 0	Completed					auto perfo	prior to death?	completion of cause of
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>	8 s D	ToB	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 Inpatient 2	ER/Outpatient 3	Other		dence 6 ☐Other (Spe	cify)
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D	itel or irs afte ret Dir iled in								
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edical	29a. Certifier Certiffing (Check only one)	hysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, death occ ation and/or investi	surred at the time, date and plac gation, in my opinion, death occ	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	A'		29c. License number		29d. Date signed (Mont.	h, Day, Year)
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	10		30. Name and address of person who	completed sauce of death (the	m 22a) /Tun= D-1 :			16106	
	10		1	1000 Fran Klin	(Type, Print	Dai 10 2-111	0.00 1/13	7172	7
2	St. St.	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature ature	yrive, Daltim	016,111	1. 4143	
	Regist		JAN 0 9 2006	Beech &	Brock	Drive, Baltim			

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		State of Maryla				vientai Hygie	ene 200c	00171
		Registrar	Cei	rtificate of l	Jeatn		, Not. UUU	001/1
Physic	cion	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
/Med		Judith Ela:	ine B	arrett		January	2 2006	8:20 A M
Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th
		Since Hospital of Bulking	e	Ball	more (uly !		
Funera	1		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Bir	thplace (State or Foreign ountry)
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ъ.		Usual Residence of Decedent	Me. Tour					1011
urylar show	_	10a. State 10b. County 10c. C	City, Town or Lo	ocation				10d. Inside City Limits 1 X Yes 2 No
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ih th or 26	Director	10e. Street and Number		10f. Zip Code		109	g. Citizen of What C	ountry?
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sep .	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Si	pecify Yes or No-	14. Race - Am Black, Whi	
or h	匠	1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 ☐ 🛣 No		1 ☐ Yes 2 🗓 No	Specify:	,		Black
ours raf.	1 by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:					Specity.	DIACK
72 h 72 h natu	ete	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king 16	6b. Kind of Business	/industry
ithin it	du	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired	1)		Commeric	al Credit
wertt	Completed	12th grade N/A	Sec	retary				
If I'd. X 1 X 1 2-0000 be filed within 72 hours after death with the Maryland tal Hygiene. I other than "natural", or items 23a or 28a-1 show event, the Martical Exemitter must be multified at	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, Ma	aiden Sumame)	
yidilio 2.12 buld be filed with Mental Hygiene. arked other than	၉	David Sykes			Carrie	Justice		
S S S S S S S S S S S S S S S S S S S		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Number, (City or Town, State,	Žip Code)
and and n 27		Charles L. Barrett			Avenue	Balto,	Md 21207	
of Table		20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Dispo cemetery, crea	sition (Name of matory or other plac	e)	Date 20	Dc. Location - City or	Town, State
permit. Pages 1 and 2 Department of Health is Important: if item 27 is any Injury or other tra		4 Donation 5 Other (Specify)	King Me	emorial P	ark 1-9-	2006	Randallst	own, Md
mit. Dartm Sorts	1	21. Signature of uneral Service Licensee	22	2. Name and Addres	ss of Facility Ma		West	
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		23a Part 1. Enter the disease, or complications that caused the de	ath. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate
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ox ording use a	W.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of preg	nancy				23d. Date of de	livery
atter for u	a	in the past 12 months?		Ectopic pregnancy Other (specify)			Month	Day Year
the d	Physician/Med	1 Yes 2 No 4 Pregnant at time of 9 Unknown						
The taw requires that the death certifical the has been signed by the attending phage 2 should be detached for use as the		Part II. Other significant conditions contributing to death but not re	sulting in the u	inderlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
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Phys this	2	TU Tes 217No 1 I Impatient 2	ER/Outpatier	IL 3 DOA	4 Nursing H		ce 6 □Other (Spe	ocify)
ing i	o o	27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	k?	28d. Describe how	injury occurred	
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fter of Alice	Certification:	4 Homicide determined 28e. Place of Injury - At building, etc. (Spec		reet, factory, office		281. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
urs a								
Hoss 14 ho Fune Fune	ca	29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner)	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my of	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	se(s) and manner a e and place, and du	s stated. a to the cause(s)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	and manner stated.						
F. W. F. S		Buyan Kamarathan M	0	0 60	-000	290	C	20AL
de				FLS	-000	Ų	January 2	, , , , ,
100		30. Name and address of person who completed cause of death (It	em 23a) (Type,	Print)		in Ai		Un 2101-
W		Ranjani Kamanathan	(1) S	mal thos	speray o	FISCULIN	un	un, Day, Year) , 20 0 6 UD 21215.
S Regis	tate	31. Ďate fileď (Month, Day, Year) 32. Refistrar's Sig JAN 0 9 2006	nature	(DEASE)	•			
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Amend item#20b,perFH, 851,1/9/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** JANUARY 4, 2006 3:10 PMM ELIZABETH ARDELLA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore FutureCare Homewood If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 G 94 -25-1911 Baltimore Director 213-20-5967 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10h Counts 10c. City. Town or Location item 27 is marked other than "naturel", or liema 23e or 28e-f show other traumatic event. The Musical Examiner must be notified at 1√XYes 2 □ No Directo Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21230 United States 1526 S. Charles Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: δ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) James Drug Store Clerk 7 years permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth-any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rose Johnson James Gravatt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 7723 Vena Court Pasadena, Maryland 21122 Michael E. Gravatt (nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 1 - 7Baltimore, Maryland 21. Ignature of Fun ral Service Licensee McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave. Baltimore. MD 212 J. Wayne Osterling E. Fort Ave. Baltimore, MD ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** CORONARY resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions.

1.47, but in 15 in module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 manths? 2 Fetal death 3 Ectopic pregnancy lor Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☑ No 9□ Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 2 No certificate 1 Yes 2 No 1 Tes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No P 1 🗌 Yes this After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 757722 MID 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SGOZ BALTMORE NATIONAL AILE #603 BALTMORE MD 21228 LEONARD RICHARDSON M.P. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygierie 🕦 🕦 🔓 State Registrar Amend Item #5 Per FH C854 4903766aten of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Andrew Joseph Bielecki Year **Physician** anuary 6 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner KOS 0 mare aa S Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Ade (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** \$212°°20'-0246 Min. Days Hours 1⊠M 2□F Vrs Director Nov. 10,1925 Ohio 80 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö or itams 23a 1932 Eastfield Road 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 271s marked other then "naturel", or item any injury or other traumatic event, the Mactical Factor 1 ☑ Yes 2 ☐ No 1 Never Married 27 Married If Yes, Give Year or Dates:WWII 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Blast Furnace Steel Industry 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helen Pelts Michael Bielecki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wife Mrs. Virginia M. Bielecki 1932 Eastfield Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cemetery 1/9/2006 Dundalk, Maryland 21. Signature of many all Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Box 68760, A Due to (or as a consequence of): the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Records. 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? (es 2011) page certificate 2 🗆 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? director, 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 V Inpatient 2 ER/Outpatient 3 DOA his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 0061402 06 30. Name and address pleted cause of death (Item 23a) (Type, Print) 9000 Franklin Square 9(31. Date filed (Month, Day, 32 Registrar's Signature Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** 658 Irene Louise Childress JANUARY 2, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GIEN BURNIE If Under 1 Year If Under 24 H A.A.COUNTY BACTIHORE WASHINGTON HEDICAL CENTER 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F Months Days Hours Director 76 11/07/1929 WV 217-24-2606 Usual Residence of Decedent liled within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Madical Exampler must be routified at 1 ☐ Yes 2 🗷 No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8081 Armiger Drive 21122 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: 3 Widowed 4 □ Divorced id Mental Hygiene. marked other than "natural", White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi. and Mental H Be Sterling Craig Simms Hazel Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 is
any Injury or other trau Danny Childress / Son 1558 Colony Road, Pasadena, MD 21122 20a. Method of Disposition Entombment
1 Darial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 Cother (Specify) 01/06/06 Cedar Hill Cem Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Conset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ģ Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the e detached f 9 Unknown certificate has been signed l rector, page 2 should be det Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 es 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. 1 Yes 2 No the Hospitel or Attending Physician: After this certific funeral director, 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24 hours a Funerel I within 2 To the I

n who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

03

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Year)

Registrar's Signature

			For Stata Registrar	State of M		artment of He			iene	6 00175
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	Funeral	-	Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplace (State or Foreign Country)
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	ns 23	Funerai	719 208th Stre	et 12. Was Decedent	Ever in U.S. 13.	21122 Was Decedent of Hisp	anic Origin? (S	pecify Yes or No-	U.S.A	- American Indian,
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f ehow ta Madical Exeminer mast be notified at	þ	1 Never Married 2 Marned 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		If Yes, specify Cuban,	Mexican, Puen Specify:	o Rican, etc.)		White, etc. White
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Maryland			19a. Informant's Name/Relationship		19b. Maili	ng Address (Street and	d Number or Ru	ıral Route Number,	City or Town, S	tate, Zip Code)
	s 1 and 2 f Health item 27 i		Barbara Chome 20a. Method of Disposition	t / Wife	719 20b. Place of Disp	208th St	reet,			21122 ity or Town, State
nor	9°= 5		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		cemetery, cre	matory or other place)	1 01			
Baltimore,	in in in		21. Signature of Funeral Septice Lice		Lakeviev		of Facility G.	J.Gonce	ykesvi Funer	11e, MD al Home, PA
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	cate be executed only sicien and the burial-transit	Examiner	that initiated events	C						
60,	be exercisen a		resulting in death) Last	Due to (or as	a consequence of):					
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Vital Records,		Completed	Chroni	c Rei	nal E	ailure		24a. Was ar autops perform 1 \(\text{Yes} \) 2	y pried? dea	ere autopsy findings available or to completion of cause of ath?
Vita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	110001000000000000000000000000000000000		6. Place of Dea	th Check only one	9)	
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Division	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined		ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Str City or Town		or Rural Route Number,
	lospita hours unera		29a. Certifier 12 Certifying Pl	hyeicien: To the best	of my knowledge, dear	h occurred at the time, vestigation, in my opini	date and place	, and due to the ca	ueu(e) and mara	of as stated.
	the H	Medical	one) 29b. Signature and title of certifier	and manner sta	ated.	29c. License n				
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			Decedent's Name (First, Middle, La.	st)					2. Date of Death	Day	Vene	3. Time of Death
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ė,	Funeral Director		227-38-6968	ex 7. Age	(In yrs. last birtho	Months		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Y 10-22-	-31	9. Birthp Coun	lace (State or Foreign try) Va.
	and		Usuat Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location					1	0d. Inside City Limits
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Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural, or iteme 23e or 28e-f ehow event, the Medical Examinar must be indiffed at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2[▼ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Deced If Yes, spec		nic Origin? (Spe exican, Puerto I pecify:	cify Yes or No- Rican, etc.)		ce - Americ ck, White, by: BI	
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Baltimore,	permit. Pages 1 Department of F Importent: if ite any injury or ot		21. Signature of Funeral Service Lice	ns ee		22. Name an	d Address of	Facility	Balt:	imore,	Md.	21202
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Я	Physician		Immediate Cause (Final disease or condition	a Conye	stive H.	ent f	ailure					5 42003
1	/Medical Examiner		resulting in death)	Due to (or as a	consequence of)							2
1 /8	Examine:	-	Sequentially list conditions,	b. Due to (or aska	consequence of)							syen
	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (01 and	consequence or,	•						
	al-trai	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of)	:						
8760	cate be executed physicien end the burial-transit	dical		d								
9	uficat g phy as th	edi										
O. Box	that the death certificate be executed ed by the attending physicien end detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 Ectopic pr 5 Other (sp				1	ite of delive onth	ny Day Year
P.O	requires that the een signed by th hould be detache		Part II. Other significant conditions	contributing to death but	not resulting in the	ne underlying c	ause given in	Part I.	23e. Did toba	cco use con	tribute to th	ne cause of death?
rds	quires n sign	d by							1 PYes	2 🗆 No	3 Prob	ably 4 ∐Unknown
of Vital Records,	e law has b	Completed		·	- t	<u> </u>			24a. Was an autopsy performe	/	Were auto prior to cor death? 1 \(\sum \text{Yes} \)	psy findings available in pletion of cause of
ital	ician: Th certificete ector, pag	Be C	25. Was case referred to medical examiner?				26.	. Place of Death	(Check only one)			
<u>}</u>	S S	70	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatien		atient 3 DC		Nursing Hor	ne 5 🗆 Residen	ce 6 🗷 Oth	ner (Specif	Hospital
ion o	ding After fune		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day	Year) 28b. Tin	ne of 2 ury M	8c. Injury at Work?		28d. Describe how	injury occui	red	•
Division	i or Attendi after death Director: A d in by the f	Certification:	3 Suicide 6 Could not be determined		y - At home, farm (Specify)	, street, factory	, office	4	28f. Location (Stre City or Town,	et and Numi State)	ber or Rura	l Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edicai	29a. Certifier 1 Certifying Pi (Check only one) 1 Medical Exa	hysician: To the best of miner: On the basis of and manner stat	examination and/	death occurred or investigation	at the time, d , in my opinio	late and place, a	and due to the cau ed at the time, date	ise(s) and m e and place,	anner as st and due to	ated. o the cause(s)
	To To to man	Σ	29b. Signature and title of certifier	Charles	,MD	290	License nur 4724	mber 3897		Januar.		Day, Year)
0	2 1		30. Name and address of person who	completed cause of de	ath (Item 23a) (T	A .	ioria)	Hospital	MD		J	
S	Sta		31. Date filed (Month, Day, Year)	32. Pegistrai	's Signature	9-10:	:					
45.7	Regist	ar	JAN 0 9 2	006 Blosses	1 15 1	portu				 		

		•	For State Registrar	(d / Depa		t of H	ealth a		lental Hyg	iene	006	0017	7
	* 6	- 30	Decedent's Name (First, Midd.	e, Last)									2. Date of Dea	th		3. Time ol Death	
Н	Physicia		Mary	(Casey								Month 01	01	Year 06	3:30 A	М
	/Medic Examin	-	4a. Facility Name (If not institutio	n, give str	eet and nu	umber)			4b. City,	Town, or	Location of	f Death		4c. (County of Dea	th	
1			Manor Care He	alth	Serv	ices	3		Pot	tomac	2			M	ontgom	ery	
	Funeral Director		5. Social Security Number 158-58-5162	6. Sex 1 □ N	1 2⊠F	_	(In yrs. 1 44	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 02 21	Year) 61		thplace (State or Foreign ountry) York	gn
	and w		Usual Residence of Decedent 10a. State 10b. County	,			10c. City	y, Town or Lo	cation							10d. Inside City Limit	ts
	Aaryla Pobo	20	VA				,	rlingt								tx⊡Yes 2 □ N	10
	28a-1	ect	10e. Street and Number				_		10f. Zip	Code				Og. Citiz	en of What Co	ountry?	
	with Sa or	٥	2400 Clarendon	B1vd	. #40	09				201				-	USA		
	ne 23	Funeral Director	11. Marital Status	12	. Was Dec	cedent E	ver in U.	S. 13.			spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	1	4. Race - Ame		
0	riter	Fur	1 Never Married 2 Mar	ried	Armed F	2 X 1N	0					, Puerto	Hican, etc.)		Black, Whit		
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2-0	be filed within 72 hours after death with the Maryland tal Hyglene. id other than "natural", or lleme 23a or 28a-f ehow event, the Medical Examinar most be natified at	Completed	15. Deceder (Specify only highe	nt's Educa	tion completed)		16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa rk done d	ation <i>Juring</i> mosi	t of worki	ng	16b. Kir	d of Business	/Industry	
2	Aithin Nen.	ig I	Elementary/Secondary (0-12)		College		+))				_		
2	filed w Hygier other th		17. Father's Name (First, Middle,	(act)	4 yı	cs.		U	nknow	n	19 Mothe	r'e Name	(First, Middle,		Gover	nment	
anc	2 should be filed within 72 hours after death with the Marylan and Mantal Hygiene. Is marked other than 'natural', or lieme 23a or 28a-1 show eumatic event, If a his licel Examine main he notified a	Be	Russell Cases										en Conno		sumame)		
ž	d Merk	욘	19a. Informant's Name/Relation		Print)			19h Mailie	a Address	/Street s			Al Route Numbe		Town State	Zin Code I	
Maryland 21215-0036	d 2 si th an 7 le r													-			
စ်	permit. Pages 1 and 2 should be Department of Health and Menia Important: If Item 27 Ie marked any injury or other treumatic a 2000.		Russell Cases 20a. Method of Disposition	/ /ra	tner		20b. P	440 Place of Dispo emetery, crei	South sition (Nar	me of	tenal	1 Dr	. Palat	ine, 20c. Loc	ation - City or	Town, State	-
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altimore,	nit. Pertme		21. Signature of Funeral Service		- 31		110	22	2. Name ar	d Addres	s of Facilit	y Mar	shall's	Fun	eral H	ome	-
Ba	Depermine Depermine Impo		1 Dom	als	Pin	00							Wash. D			om c	
	Nº So		23a. Part1 Enter the disease, of shock or heart lailure. Lis	r complica	tions that	caused	the death	h. Do not ent	er the mod	le ol dying	g, such as	cardiac c	or respiratory an	est,		Approximate Interval Between	
**	Physician		Immediate Cause (Final	t only one	A A	eaci iii) Mu	Olin	0, 9	bolo	2006	: (Onset and Death	
N.	/Medical		disease or condition resulting in death)	a.	Due to	o (or as a		uence of):	11	α .	2016	YU)				
	Examiner		Conventially list conditions	b.													
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	"	Due to	(ur as a	conseq	uence or).									
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	Durate	/											
760,	ate be executed sysician and he burial-transit		Todating it deatiny East		Due	or as a	a conseq	uence of):									
687	physic	edical		d.													-
9 ×	eath certificat ettending phy I for use as the	/Me	IF FEMALE:	230	. If ves. o	utcome o	of pregna	incv						,	3d. Date of de	làsea	
Bo	eath e	cian	23b. Was decedent pregnant in the past 12 months?		1 Live	birth :	2 ☐ Feta time ot d	I death 3	Ectopic pi					-	Month	Day Year	
P.O. Box	that the de led by the e detached f	Physician/M	1 ∐ Yes 2 ⊠No 9 ☐ Unknown		9□ Unk					,,							
	The law requires that the death certifica ate has been signed by tha ettending ph page 2 should be detached for use as it	by Pt	Part II. Other significant condit	ions contr	buting to	death bu	t not res	ulting in the u	nderlying o	ause give	en in Part I		23e. Did to	bacco us	se contribute t	the cause of death?	
g	w requires to been signed should be a	D D											1 🗆 Y	es 2[No 3□P	robably 4 🔊 Unknow	M n
Records,	s bee	Completed											24a. Was		24b. Were a	utopsy lindings availab	ole
æ	eician: The law s certificate has t irector, page 2 s	E							-				autop perfor	med?	death?	completion of cause of	
ita	Physician: The l this certificate he ral director, page	Bec	25. Was case referred to medical	al							26. Place	of Death	Check only or	-			
>	Physician: r this certificatal director, a	10 E	examiner? 1 ☐ Yes 2 ☒ No	Но	spital: 1 [Inpatier	nt 2	ER/Outpatier	nt 3 DC	Othe Othe	9F. 4 🐼 Nu	rsing Ho	me 5 Resid	ence 6	□Other (Spe	ecify)	
0		ü	27. Manner ol Death 1 ☑ Natural 5 ☐ Pend	ina	28a. Date (Mo	e of Injur onth, Day	Year)	28b. Time o	f 2	28c. Injun Work	at c?		28d. Describe h	ow injury	occurred		
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Division of Vital	or Attendate death Director:	Certification;		mined	28e. Plac	ce of Inju ding, etc	iry - At ho :. (Specif	ome, larm, st y)	reet, factor	y, office		:	281. Location (S City or Tow		Number or R	ural Route Number,	
	urs a	0	29a. Certifier 1. Certify	as Dhusi	-i T- 41		4 1					d -1					
	To the Hospital or Atterwithin 24 hours after de To the Funerel Directo completely filled in by the	ledical	(Check only 2 Medica one)	I Examine	r: On the and ma	basis ol inner sta	examina ted.	ition and/or in	vestigation	, in my of	pinion, dea	th occurr		ate and	place, and du	e to the cause(s)	
	vith To t	Σ	29b. Signature and title of certifi						29	c. License	number	_		29d. Date	signed (Mon	th, Day, Year)	
)			,	/					1	1605	>456	6		DNG	ary 1	12006	
			30. Name and address of person	who com	pleted car	use of de	eath (Iten	n 23a) (Type,	Print)			. 1		_		2 10 2 2	
	Sta	, io	31. Date filed (Month. Dav. Yea.	pu	32	Resistra	A Ed	ature a	Par	000	, Xe	142	30 10C	2501	UOTP	-1286.	
JA!	Regist		29b. Signature and title of certification of periods of	9 20	06	No.	wa	N.	Spark								

		1 - For State Registrar	State of Maryla	and / Depa		of H	ealth a		•		_	6	0 0	178)
Dhuoie	ion	1. Decedent's Name (First, Middle, Las	")		Cus				2. Date of De Month			rear		me of Death	Ī
Physic /Med		RICHARD			Cuc				TANVAR	7 6	20	06	17	736	М
Exami	ner	4a. Facility Name (If not institution, give		2- 1	4b. City, 1		Location of	f Death		4c.	County o				
	* *	THE JOHNS HOP 5. Social Security Number 6. Se		rs. last birthday)			If Under 2	24 Hrs.	8. Date of Bi	rth		N/		tate or Forei	ior
Funeral Director		,	21M 2□F 47	Yrs.	Months	Days	Hours	Min.	July .	6^{Year}	958	Mar	vla	itate or Forei nd	911
<u> </u>		Usual Residence of Decedent			-	-									
arylar	_	10a. State 10b. County		City, Town or Lo								1		ide City Limit]Yes 2 ⊡+N	
Ba-f	Director	Maryland Anne Ar	undel GI	en Burn		Codo				10= 0:4:	zen of Wh	-10		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	_
with t	Ö		n+ /.		10f. Zip	2106	1			-	U.S.		uy :		
ING 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Madical Expiniter must be ricillised.	Funerai	1020 Cayer Drive A	12. Was Decedent Ever in	U.S. 13.				gin? (Spec	cify Yes or Na Rican, etc.)		14. Race	Americ		an,	
or Iter	F	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, spec			, Puerto P	Rican, etc.)			White,	∍tc.		
ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Li Yes 2	No	Specify:				Specify:	Wh	ite		
72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa	ation furing most	of workin	g	16b. Ki	nd of Bus	ness/Ind	lustry		
within 72 ene. then "nell ne Merilla	m d	Elementary/Secondary (0-12)	College (1-4or 5+) N/A	iire.	P1uml		,			D111	mbin	a Co	mna	nv	
Hygie other	ပိ	17. Father's Name (First, Middle, Last)	N/A		1 Lumi	Jer	18. Mother	r's Name	(First, Middle	-		_	пра	113	
	To Be	Anthony		Cucin	a		Fra	ances	5			R	yan		
ary shou	Г	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address	(Street a	and Number	r or Rural	Route Numb	er, City o	Town, S	tate, Zip	Code)		
re, Maryls s tand 2 should f Health and Mer trem 27 ts marke		Kathleen Cucina							ndalk,						
Baltimore, permt. Pages 1 ar Department of Hea Important: if Item: any injury or other once		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐	20b Removal from State	o. Place of Dispo cemetery, cre-	osition (Nam matory or ot	ne of ther place	θ)		ate		cation - C				
tim tent: tent:		4 □ Donation 5 □ Other (Specify		restlaw							svil		ary	Land	
Battimore, I permit. Pages 1 and Department of Healtil Important: if them 2? any injury or other a		21. Signature of Funeral Service Licen:	500	M	cCully	y –Po	lynia	k Fur	neral l	Home,	P.A		011	00	
To the last		23a. Part Inter the disease, or comp	lications that caused the de						asade		laryı	and		ZZ ximate	
		23a. Part I nter the disease, or comp shirt, or heart failure. List only of Immediate Cause (Final							,,				Onset	al Between and Death	
Physician /Medical	1	disease or condition resulting in death)	a. MULTI O		FAIL	URE	,					_ 2	. W	eeks	
Examiner			CEPTIC		T							2	-IVita	na Tens	
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± 0 €	by Physician/Med	IF FEMALE:	23c. If yes, outcome of pre	nnancy							24 0-44	-4 -4 -45			
P.O. BOX net the death cer d by the ettendir etached for use	cian	in the past 12 months?	1 Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	☐Ectopic pre☐ Other (spe					2	3d. Date Monti		Day	Year	
the d wy the	ysi	1 □ Yes 2 ⊠ No 9 □ Unknown	9□ Unknown												
s thet ned be deta	y P	Part II. Other significant conditions co	entributing to death but not	resulting in the u	inderlying ca	ause give	en in Part I.		23e. Did	tobacco u	se contrib	ute to th	e caus	e of death?	
rds quire en sig									1 🗆	Yes 2	□No 3	☐ Prob	ably	4 Unknow	٧n
2 8 B	Completed								24a. Was		24b. We	ere auto	osy finc	dings availab	ile
f Vital Re lysician: The l lis certificete ha director, page	E O								perfe	ormed?	de	ath 7	2/2 No		
vision of Vital F Attending Physician: Th r death. ector: After this certificete by the funeral director, pag	Be (25. Was case referred to medical examiner?						of Death	(Check only	опе)					_
Of Physic this caldire	ဥ	1 □ Yes 2 No		ER/Outpatie			4 LI NUI		e 5 ☐ Res)		
On C	lon:	27. Manner of Death 1 XNatural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time o	M 2	Bc. Injury Work	rat ⟨? Yes 2		8d. Describe	how injury	occurred	1			
isic death death ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	t home, farm, st			163 2		8f. Location (Street and	d Number	or Rura	l Route	Number.	
Div after after Dire	Certification:	4 Homicide determined	building, etc. (Spe		.001, 1201019	, omoo				wn, State,					
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		29a. Certifier 1 Certifying Ph	sician: To the best of my	knowledge, deat	h occurred a	at the tim	ie, date and	d place, a	nd due to the	cause(s)	and manr	ner as st	ated.		-
n 24 I he Fu he Fu	edicai	(Check only 2 Medical Examone)	iner: On the basis of exam and manner stated.	ination and/or in	ivestigation,	in my or	oinion, deat	h occurre	d at the time.	date and	place, an	d due to	the ca	use(s)	
To the To the comp	Σ	29b. Signature and title of certifier	000		29c		number	^^	^		e signed (
		MI	~ MD			Kt	-7 -	\cup	0	JANU	ARY	φ_{j}	20	206	
le		30. Name and address of person who o				-	BALT	IMIN	£	0 311 1	214	2.1	9 (3 ·m		
DESCRIPTION OF REAL PROPERTY.		DEGA SARMA (31. Date filed (Month, Day, Year)	32. Registrar's Signature		1 KCE		סחני	11 4100	- ma	RYLA	100	21	-3 +	-	
Si Regis	ate trar	JAN 0 9 2	1 3657		F 10										
DHMH 17 Rev 1/		Unit U J Z	006	N A			1000	61.F/							

			For State Registrar	State of Maryland		artment of He			giene Reg. No. 006	00179
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, L BEVERLY 4a. Fecility Name (If not institution, g University Hos	Deboard ive street and number)	9	4b. City, Town, or Lo		2. Date of Dea Month January	Day Yea	0051 M
	Funeral Director		5. Social Security Number 6. 134-60-2735 Usuel Residence of Decedent	Sex 7. Age (In yrs. Iz	Yrs.	Months Days	Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day MAY 20	y, Year) 9. E	irthplace (State or Foreign Country)
	with the Maryland to 28e-f ehow the notified at	ector	10a. State 10b. County H /- 10e. Street and Number	HRFORS 10c. City	Town or Lo	ARLINGTO	N		10g. Citizen of What	10d. Inside City Limits 1 Yes 2 No
9	death	Funeral Director	1	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give		Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	U. S. F 14. Race - Ar Black, WI Specify:	nerican Indian,
Maryland 21215-0036	nin 72 hours n. "natural", Medical Exa	Be Completed by	3 Widowed 4 Divorced 15. Decedent's (Specify only highest selementary/Secondary (0-12)	Year or Dates:	16a. Dece	dent's Usual Occupation kind of work done dur DO NOT use retired)	on		16b. Kind of Busines	•
yland 2	be filed ital Hygi of other event, I	To Be Co		ANDVOLD		11	B. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
	s 1 end 2 sh f Health and item 27 le m other treum		19a. Informant's Name/Relationship Bevelly / + Avv 20a. Method of Disposition #Burial 2 Cremation 3	20b. PI	290	Address (Street and Willows Sition (Name of matory or other place)	Lby Rb	. BA Ito.	20c. Location - City	or Town, State
Baltimore,	permit. Page Department o Importent: If any injury or once.		4 Donation 5 Other (Spe 21. Signature of Funeral Service Lic	city) OA	KL AW!	CEM. 2. Name and Address ARTLEY Mi			BALTOM UNERAL HE MD 212	D. ome CHTO.
	Pnysician /Medical		23a. Part 1. Enter the disease, or co shock, or heart lailure. List on tmmediate Cause (Final disease or condition resulting in death)	ly one cause on each line.	Do not en	ter the mode of dying,				Approximate Interval Between Onset and Death
760, 4	te be executed ysiclen and te burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) c. Due to (or as a consequence) d.	enge of):					
O. Box 68	eath certif ettending for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9% Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time ol de	death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of Month	detivery Day Year
ords, P.O.	w requires that the de been signed by the should be detached	ted by Ph	Part II. Other significant conditions	s contributing to death but not resu	ulting in the u	underlying cause given	in Part I.	23e. Did to		to the cause of death? Probably 4 □Unknown
tal Reco	iiclen: The law r certificete has be rector, page 2 sh	Completed	25. Was case referred to medical				Ge Place of Dea	24a. Was autor perfo Yes	osy prior death 2 No 1	
f Vii	Physicie this cert el direct	To Be	examiner? 1 Ç X es 2 ☐ No		^	nt 3 DOA Other	4 ☐ Nursing H	ome 5 Resi	dence 6 Other (S	pecify)
Division of Vital Records,	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investiga 6 Could no determin	be One Blees of laive, At he	me, larm, si	Work? M 1 □ Ye	at es 2⊠No	PEDESTA 281. Location (Street and Number or	
ā	To the Hospital or Attencylin 24 hours after death To the Funeral Director: completely filled in by the	Medical Cer	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of my kno caminer: On the basis of examina	wledge, dea	th occurred at the time	, date and place nion, death occu	, and due to the	cause(s) and manner	as stated.
	To the l	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date signed (Me	
	•		111011	10, MA			nn Stree		•	yland 21201
	St Regist	ate rar	31. Date liled (Month, Day, Year) JAN 0 9 200	32. Registrar's Signa	- Andrew	ونع				

			1 - For State of Ma	-	artment of Health and I	Mental Hygie	2000 00100
	Physicia		1. Decedent's Name (First, Middle, Last) Elizabeth Louise Diven			2. Date of Death Month	Day Yeer 3. Time of Death
	/Medic					Jan. 0	
	Examin	er	4a. Facility Name (If not institution, give street and number) Charlestown Care Center		4b. City, Town, or Location of Death Catonsville	1	4c. County of Death Baltimore
	Funeral			e (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		215-10-6527 1□M 2፟MF	89 _{Yrs.}	Months Days Hours Min.	June 19,	
	pu k		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	Aaryla I sho	ō	Maryland Baltimore	Catonsvi			1 ☐ Yes 2 🛣 No
	28e-	rect	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	h with	ai Di	715 Maiden Choice Lane #	PV519	21228		USA
	ems 2	ner	11. Marital Status 12. Was Decedent Armed Forces?		Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
36	s afte , or it	y Fu	1 Never Married 2 Married 1 Yes, Sive 1 Fyes, Give Year or Dates:	No l	1 ☐ Yes 25 No Specify:	•	Specify: White
21215-0036	within 72 hours after death with the Maryland ane. then "neturel", or items 23e or 28e-f show he Medical Ess rifer must be notified at	Completed by Funeral Director	3 Vidowed 4 □ Divorced Year or Dates: 15. Decedent's Education	16a, Deced	tent's Usual Occupation	166	b. Kind of Business/Industry
215	nin 72 In "ne Medic	piet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	kind of work done during most of wor DO NOT use retired)	king	,
212	ad with	E O	12	Ret	ail Sales	H	utzler's Dept. Store
nd	be filk d oth event	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Mai	den Surname)
Maryland	d Men marke	To	Rowland Rees	10h Marilin	Kathe	rine Hens	
Z	d 2 st th and 27 is r treur		19a. Informant's Name/Relationship (Type, Print) Louis Hugh Diven, Jr. S		Kimberly Lane; Mo		
	s 1 an f Heal tem 2		20a. Method of Disposition	20b. Place of Dispo			: Location - City or Town, State
E	Page: nent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		Cemetery 01/	10/2006	Baltimore, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumetic event, I'm Medical Exscriper must be notified at once.		21. Signature of Funeral Service Licensee	22	Name and Address of Facility te Funeral Home of C 1630 Edmondson Av	rling Asht atonsville enue:Cator	ton Schwab Witzke e,Inc. nsville, MD 21228
			23a. Part1. Enter the disease of complications that caused shock, or heart failure. List only one cause on each lin				Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition a.	Deme	ntia		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as	a consequence of):			
	•	e	Sequentially list conditions, if any, leading to immediate Due to (or as	a consequence of):			
K	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c				
o,	te be executed ysician and te buriat-transit	Еха		a consequence of):			
8760,	icate be executed physician and s the buriat-transit	dicai	d				
9 X	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome	of pregnancy			23d. Date of delivery
Вох	death a atten d for u	ician	230. Was decedent pregnant in the past 12 months? 1 Vac 2 No. 4 Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)		Month Day Year
P.O.	it the c by the tacher	hys	9 Unknown				
	res that the de igned by the a be detached f	ру Р	Part II. Dther significant conditions contributing to death b	ut not resulting in the u	nderlying cause given in Part I.		co use contribute to the cause of death?
ord	w requir been si should I	sted				1 Tes	2 No 3 Probably 42 Unknown
3ec	9 7 9	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
a	icien: The certificate ha rector, page	e Co	25. Was case referred to medical		00.51 (.5	1 □ Yes 212	
of Vital Records,	Physicien: r this certific ral director,	To Be	examiner?	nt 2 ☐ ER/Outpatien		th (Check only one) ome 5 □ Besidence	e 6 ☐Other (Specify)
ا و ر	g Phy ter thi		27. Manner of Death 28a. Date of Inju			28d. Describe how i	
sior	Attending r death. ector: After	atic	2 Accident investigation	, , , , , , , , , , , , , , , , , , , ,	M 1 ☐ Yes 2 ☐ No		
Division	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Inj building, et	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number. State)
_	spitel	a C	29a. Certifier Certifying Physician: To the best	of my knowledge, death	occurred at the time, date and place	and due to the caus	e(s) and manner as stated.
	ne Hoor 24 h	edicai	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or inv	vestigation, in my opinion, death occu	rred at the time, date	and place, and due to the cause(s)
	To the within To the comp	N	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
	/		1 mn		D47447	Ju	mong 4th 20th
	15		30. Name and address of person who completed cause of d	0	Print)	gtonsvill	1 May 21278
	Sta	te		ar's Signature	loig land (. (10.6)
	Registr		JAN 0 9 2006	w B. A	carle		

Warren T. Fleming Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-0121 State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Dec dent's Name (First, Middle, Last) 2. Date of Death Month **Physician** larren January 2006 10:32 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6901 Security Boulevard Baltimore County Woodlawn 5. Social Security Number 220-94-303 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Jonth Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**1M 2□F Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10d. Inside City Limits in then "natural, or itema 23a or 28a-1 ehor MD Baltimore 1 ☐ Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7613c 21244 Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ **X**o Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Fither's Name (First, Middle, s Name (First, Middle, Be le.mina 19b. Mailing Address (Street and N Heelth : 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location Burial 2 Cremation 3 Removal from State 21. Signature of Funeral Service Licentee nera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Gurchot wound to the head /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): .O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 **X** No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? death? 1 Yes 2 No 1 X Yes 2 🗆 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6XXX ther (Specify) at SCENE Hospital: 1 (XYes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA s efter death.

I Director: After this id in by the funeral di 28d. Describe how injury occurred subject was 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 No investigation 2 Accident 10:30 3 Suicide
4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) (SiOI Section Elva within 24 hours effort To the Funeral Di Parking 101 1 Certifying Physicien: To the best of my knowledg death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 to the discal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 6, 2006 no completed cause of death (Item 23a) (Type, Print) Hamele 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

32, Registrar's Signature

3 Page

JAN 0 9 2006

		•	For State Registrar	State of M	laryland /		irtment of F tificate of	Health and I Death		jiene () () leg. No.	6	00182
	Physicia		Decedent's Name (First, Middle Earl	Clifford	F	urro	w, Jr		2. Date of Dea Month January	Day	6 ^{Year}	3. Time of Death 2:18 рм
	/Medic Examin		4a. Facility Name (If not institution	, give street and number,)		4b. City, Town, o	r Location of Deat	h	4c. County	of Death	
186	Funeral Director	25	Baltimore—Wa 5. Social Security Number 215-30-9544	ashington Ho 6. Sex 1 \(\text{\$\mathbb{H}} \) M 2 \(\text{\$\mathbb{F}} \)	esptial ge (In yrs. last I 72	oirthday) Yrs.	Glen Bu If Under 1 Year Months Days			1	e Arı ^{9. Birthp} <i>Cou</i> r Mary	inde1 blace (State or Foreign off) Vland
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation				1	Od. Inside City Limits
	Mary a-f eh	tor	Maryland Anne A	Arundel	Linthi	cum	Heights					1 Yes 2 No
	or 28	Direc	10e. Street and Number				10f. Zip Code	.00		10g. Citizen of V	Vhat Cour	ntry?
	e 23a	eral	107 Coronet Dri	.ve	Ever in 11 S	12.1	210		Chacify Vas or No-	USA	a - Americ	can Indian,
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or iteme 23a or 28a-f ehow event, the Medical Examir at must be mutified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marria 3 □ Widowed 4 □ Divorced	Armed Forces	? No		Yes, specify Cubi	dispanic Origin? (S an, Mexican, Puerl Specity:	to Rican, etc.)	Specify	k, White,	
5	n 72 h	Completed	15. Decedent (Specify only highes	's Education t grade completed)	16	(Give	lent's Usual Occup kind of work done	pation during most of word)	rking	16b. Kind of Bu	usiness/In	dustry
2121	within ione.	ошо	Elementary/Secondary (0-12)	Cottege (1-4or	5+)		ts Depar			Auto/T	rucki	ing
	al Hygid I other vent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nar	me (First, Middle,	Maiden Surnam	10)	
aryland		To	Earl C		urrow,			Sarah		abeth		Dennis
Mar	s 1 and 2 should 1 Health and Mer Item 27 ie marke other traumatic		19a. Informant's Name/Relations	, , , , , ,				and Number or Ru				-
ē,	Health tem 27 other tra		Kathleen E. Fu	irrow (wile)	20b. Place	of Disco	sition (Name of natory or other place	r., Lint	Date He	20c. Location -		
altimore,	t. Page rtment o rtant: if njury or		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S) 21. Signature of Funeral Service	oecify)		n Pa	rk Cemet Name and Addre	ery 1/9				Maryland
Ba	Depa Impo eny is		1/2					ens Ave.	oudon Par . Baltimo			
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that cause only one cause on each	ed the death. D							Approximate Interval Between Onset and Death
	/Medical Examiner	_	resulting in death) Sequentially list conditions,	6. Coron	s a consequence s a consequence	BIC	ery i	Ducan	V	·		37eon
	uted d ansit	Examiner	Sequentially list condifions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	\$.	5 4 5000	0.,.	U					
58760,	icate be executed physician and s the burial-transit	edical Exa	resulting in death) Last	Due to (or as	s a consequenc	e of):				7		
_		Med	IF FEMALE:									
P.O. Box	The law requires that the death certifule law requires that the attending ate has been signed by the attending bage 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetal dea at time of death		Ectopic pregnancy Other (specify)	у		23d. Dai	e of delive	ery Day Year
	es thai gned t	by P	Part II. Other significant condition	/1	buf not resulting	in the u	nderlying cause giv	ven in Part I.				he cause of death?
ord	w requir been si should	eted	Careman	a 3 renur					102	es 2 □No	3 Prob	pably 4 Unknown
Division of Vital Records,		Completed							24a. Whas a autop: perfor 1 ☐ Yes	med?		psy findings available mpletion of cause of
Ħ	Attending Physician: r death. ector: After this certifics by the funeral director, I	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ient 2 R/	Outnation	t 3 DOA Ott	205	ath (Check only or Home 5 ☐ Resid		or (Specif	
o	g Physical this neral di	-	27. Manner of Death	28a. Dafe of Inj	ury 28t	. Time of			28d. Describe h			y)
Sion	ending I sath. or: After he funer	atlo	1 Datural 5 Pendin 2 Accident investig	gation	uy / 5u//	,a.y]Yes 2□No				
D X	in Sign	Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 286. Place of Ir	njury - At home, efc. <i>(Specify)</i>	farm, str	eet, factory, office		28f. Location (S City or Tow		er or Rura	al Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	edical	(Check only 2 Medical one)	g Physician: To the bes Examiner: On the basis and manner s	of examination	lge, deatl and/or in	occurred at the tild vestigation, in my o	me, date and place opinion, death occu	e, and due to the curred at the time, c	ause(s) and ma late and place,	inner as s and due to	tated. o the cause(s)
,	To the within To the comple	Σ	29b. Signature in title of certifie	MO Atten	dup &	octo	29c. Licens	2-16 f	4	29d. Date signed	d (Month, 05 /	Pay, Year) 200 G
4	V		30. Name and advess of person	who completed cause of	death Item 23a	Туре,	Print) B	WY, PAS	HOENA	MD	2112	72
THE REAL PROPERTY.	Sta Registi		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	130	eli)					

		For State Registrar	State of	Maryland / De	oartmen e <i>rtificate</i>			nd Mental I	Hygie Rag.	600	6 00183		
Physic	ian	Decedent's Name (First, Middle, La						2. Date of Month	Death	Day 4	Year 1.25 P.		
/Medi Exami		LEO L. FIS 4a. Facility Name (If not institution, give		er)	4b. City,	Town, or	Location of		nan	4c. County			
		BALTIMORE-WASHI			GLEN					ANNE	ARUNDEL		
Funeral Director			Sex 7. I□M 2□F XX	Age (In yrs. last birthda 88 Yrs.	Months	Days	If Under 2 Hours		, Day, Y		Birthplace (State or Foreigh Country) MD		
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limit		
death with the Maryland me 23s or 28s-f ehow	tor	MD ANNE AR	INDEL.	GLEN BU	RNTE						1 □Yes 2 □ N		
or 28s	Direc	10e. Street and Number			10f. Zip	Code			10g	. Citizen of \	What Country?		
eath w	Funeral Director	3 OLD STAGE RD	12. Was Decede	ent Ever in U.S.		1061	spanic Orio	in? (Specify Yes o	r No-	· ·	ISA e - American Indian.		
<u>ĕ</u> ≗ ≅	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forc XXYes 2 If Yes, Give Year or Date	□No	If Yes, spec		Specify:	in? (Specify Yes o Puerto Rican, etc.)		ck, White, etc.		
5-003	ted	15. Decedent's E	ducation	16a. De	cedent's Usua ve kind of wo	al Occupa		of working	16	b. Kind of B	usiness/Industry		
afthin 7	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	DO NOT us	se retired,)	or working					
Hygier ther th		17. Father's Name (First, Middle, Lasi	")		TIME K	EEPE.	_	r's Name (First, Mic		SHIP Y			
Maryland 21215-0036 d 2 should be filed within 72 hours aff the and Mental Hygiene. 77 is marked other then "natural", or traumatic event. It a Mudical Exam.	To Be	JAMES FISHER	,				entil	, , , , , , , , , , , , , , , , , , , ,			•		
larylan 2 should be and Mental 1s marked sumatic ev		19a. Informant's Name/Relationship			•	-		r or Rural Route No		•			
and 2 and 2 m 27 i		DENNIS JAMES FIS	HER				D GLE	N BURNIE,	_				
Baltimore, semit. Pages 1 a Department of Hei mportant: if Item in y Injury or othe unce.		20a. Method of Disposition 1XXXBurial 2 Cremation 3		ate	rematory or o	ther place		Date			City or Town, State		
Baltimor permit. Pages: Department of P Important: if Ite eny Injury or of		4 Donation 5 Other (Specify) GLEN HAVEN CEMETERY 1,9.2006 GLEN BURNLE, MD 22. Name and Address of Facility FINK FUNERAL HOME, P.A.											
Balt Depart Import eny Inj		MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061											
		23a. Part1. Enter the disease, or conshock, or heart failure. List only		ised the death. Do not	enter the mod	e of dying	g, such as o	cardiac or respirato	ry arrest	,	Approximate Interval Between		
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/Medical Examiner		resulting in death) Bue to (or as a consequence of the conditions, if any, leading to immediate to (or as a consequence of the conditions, but the conditions, but the conditions, but the conditions, but the conditions of the conditions of the conditions, but the conditions of the											
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I Records, P.O. Box 61 The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnancy						23d. Da	ite of delivery		
Box death cer e attendir d for use	iciar	in the past 12 months?	4□Pregnar	nt at time of death	3 □Ectopic pr 5 □ Other (sp				_		onth Day Year		
P.O. at the de de de de de de de de de de de de de	hys	9 Unknown	9□ Unknow										
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cord w requir been si should	Completed							242.1	Mas an		Were autopsy findings availab		
I Rec The law ete has page 2 s	ршо							a	autopsy performe	d?	prior to completion of cause of death?		
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f Viii ysicia iis cert directe	To B	examiner? 1 Tes 2 No	Hospital:	patient 2 ER/Outpa	tient 3 DC	Othe		rsing Home 5 🗆 f		e 6 Oth	ner (Specify)		
vision of Vital Attending Physician: r death. ector: After this certifical by the funeral director.	L:no	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of (Month)	Injury 28b. Time Day Year) Injur	e of 2	28c. Injury Work	at	28d. Desci	ibe how	injury occur	red		
ision Attendir death. ctor: Al	catle	2 Accident investigate 3 Suicide 6 Could not	on		М		Yes 2 1		/61-				
Division of Vital Records, for Attending Physician: The law requires talter death. Director: After this certificate has been signs in by the funeral director, page 2 should be	Certification:	4 Homicide determined	28e. Place of building	f Injury - At home, farm, g, etc. <i>(Specify)</i>	street, factor	y, office		City of	on (Stree r Town, S	state)	ber or Rural Route Number,		
Hospita 4 hours Funeral	ledical Co	29a. Certifier Certifying P (Check only one) Madical Exa	hysician: To the b miner: On the bas and manne		eath occurred r investigation	at the tim	ne, date and pinion, deat	d place, and due to th occurred at the ti	the caus	se(s) and ma	anner as stated. and due to the cause(s)		
To the Hos within 24 hd To the Fun completely	₩	29b. Signature and title of certifier			290	c. License	number		29d	. Date signe	ed (Month, Day, Year)		
		Azartini.		MD		04	397	7	50	sma	m 4 700		
0		30 Name and a rest of person who	completed cause	of death (Item 23a) (Ty	oe, Print)	02	, a`	01 0		me.	- //		
		31. Date lied (Month, Day, Year)	Tung.	30 / TVSF gistrar's Signature	ptal	175	evx)	hen s	m,	me.	Mo. Ciobi		
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6, **Physician** Mary Jeanne Frazier 2:15 p Jan. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Long View Nursing Home Manchester Carroll If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 19-18-2717 1 ☐ M 2 ☐ F Yrs. Land **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State 28e-fahow Carroll ret, or items 23a or 28e-f ahov Examiner must be notified at Hampstead 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2137 Albert Rill Rd. 21074 U.S.A. Funerai death 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 δ 3 Divorced 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry th and Mental Hygiene.

77 is marked other than "nature treumatic event, it is Medical. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Supervisor Balto. Co. Library 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other treumatic event 908. Be John Herbert Braker Eva Margaret Herbert ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marc S. Frazier - Son 2137 Albert Rill Rd. Ham stead. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Jan. 7,2006 Baltimore, Md. * 4 □ Donation 5 □ Other (Specify) Charmil Dr. 22. Name and Address of Facility 21. Signature of Puperal Service Licensee Eckhardt Funeral Chapel, P.A.Manchester, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumon disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner true fortmoney Deser Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, physician Completed by Physician/Medical signed by the attending phys IF FEMALE 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 2 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ₫ No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death After Injury 1 Natural 5 Pending 1 Tyes 2 No investigation within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier polition D 25743 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 688 Pode Road Westnins half oton JUhm 31. Date filed (Month, Day, Year) 32. Registran's Signature State Registrar

			For State Registrar		aryland / De	partment of herificate of	Health and M	lental Hyg) 6	0018	35
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	/Medic Examir	cal	4a. Facility Name (If not institution, give s	L.	Г		or Location of Death	UANUAK		nty of Death	8:25	Ам
14	L Adiiii	iei	2 TROLOD COURT #				OWINGS	MILLS			IMORE	
N. S.	Funeral Director		5. Social Security Number 6. Sex 090~36~8204	7. Age	e (In yrs. last birthda 58 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, JUN 21	, 1947	9. Birth Cou	place (State or ntry) N	r Foreign Y
	laryland show		10a. State 10b. County		10c. City, Town or	Location					10d. Inside Cit	y Limits
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Maryland		ToB	BEN		FEINGO		ANITA				ZUCKER	
Mar	95N#		19a. Informant's Name/Relationship (Ty) RENEE FEINGOLD /			iling Address (Street 5 YOUNG WA					Code)	
	s 1 au f Hea itam othe		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other plai				n - City or T	own, State	_
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			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused e cause on each lin	the death. Do not e	inter the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Betw Onset and D	veen
3	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cor	orany	aitey	Difer	21			M	<u>†</u>
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.O. Box	The law requires that the death certilica Ite has been signed by the attending ph page 2 should be detached for use as it	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	B⊟Ectopic pregnancy B⊟Other (specify) _	у			Date of delive Month	,	'ear
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	10		30. Name and address of person who co	mpleted cause of de			A	D d	((3	6		
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	Physici /Medic	_	1. Decedent's Name (First, Middle, Last) ELSIE FANTT				2. Date of Deat Month JANUA		3. Time of Death 4:00A _M		
	Examin Funeral	er	4a. Facility Name (If not institution, give street and number) 2929 FAIRVIEW ROAD 5. Social Security Number 6. Sex 7. Age (In yrs. last		4b. City, Town, or WOODLA If Under 1 Year Months Days	WN		4c. County of De	IMORE		
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Baltimore,	permit. Pages Department of Important: If I any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Rineral Service Licensee	22	2. Name and Addres	s of Facility H	OWELL E	UNERAL I	HOME 21207 LTIMORE, MD		
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_	4		30 Name and address of person who completed cause of death (Item 23	Ba) (Type,	Print) W.	Belvede	- Ar,	CHSZY B	Oping Md		
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		•	For State Registrar						Death			Reg. No.	Ub	00187
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Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Lice	ensee		2	2. Name a	nd Addres	s of Facility	У	37 3 3			
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4) 0		30. Name and address of person w	IT MIMS	death (Item	1 23a) (Type, 4	W.	ROL	UNG	Ci	23 2055 RG	OPPOS	BA	cto, ND
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Physician /Medical Registrar 1. Decedent's Name (First, Middle, Last) Lillian Elaine Grempler		illicate of L	Death	Red	g. No.	00100				
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4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	sville		4c. County of Deat					
418 Harwood Road Funeral 5. Social Security Number 6. Sex 7. Age (h	In yrs. last birthday)	if Under 1 Year	If Under 24 Hrs.	8. Date of Birth		holace /State or Foreign				
	3 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) Feb. 28,	1922 Mar	yland				
Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Lo	ocation				10d. Inside City Limits				
Maryland Baltimore	Catons					1 ☐ Yes 2 ♣ No				
Maryland Baltimore 100. Street and Number	Catons	10f. Zip Code		100	g. Citizen of What Co	untry?				
418 Harwood Road		212	28		USA					
10a. State 10b. County Maryland Baltimore 10c. Street and Number 418 Harwood Road 11. Marital Status 1		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🛣 No	spanic Origin? (Spe i, Mexican, Puerto Specify:	ocify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Who	e, etc.				
(Specify only highest grade completed)	tion uring most of worki	n <i>g</i> 16	6b. Kind of Business/	·						
N PER 12 17. Father's Name (First, Middle, Last)	Cle		18. Mother's Name	(First Middle Ma	Librar	У				
Tr. Father's Name (First, Middle, Last) Lawrence C. Lent				h Cook	adon damamo,					
19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street ar	nd Number or Rura	l Route Number, (City or Town, State, 2	(ip Code)				
Donna I Cheare Daughter	1205	Tugwell 1	Drive; Ca	tonsvill	e, MD 212	28				
□ ♥ ♥ ► 1 TRucial 2 □ Cromation 3 □ Demoval from State		osition (Name of matory or other place Park Ceme) !		odlawn, M					
21. Signature of Funeral Service Licensee	22 W	Name and Address Fun Edition	of Facility eral Home dsons Ave	of Cato	nsville,	IMD 21228				
Fhysician disease or condition (Marking in death)	23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):									
Sequentially list conditions, bb	consequence of):									
Causé. Enter Underlying Causé (Disease or influry that initiated events resulting in death) Last Due to (or as a co	onsequence of):									
N IF FEMALE:										
The second of th	Fetel death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year				
도 영향 Part If. Other significant conditions contributing to death but n	not resulting in the u	nderlying cause giver	n in Part I.		cco use contribute to					
Hecconditions and the second s				24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of				
25. Was case referred to medical examiner?			26. Place of Death	(Check only one)						
T A STATE TO THE STATE OF THE INPATIENT	2 ER/Outpatier		4 Nuising Hot	ne 5 Residence 28d. Describe how	ce 6 Other (Spec	cify)				
C	ear) Injury	M 1 □ Y	? es 2 □ No		et and Number or Ru					
2 Accident investigation 3 Suicide determined 28e. Place of Injury building, etc. (3) 4 Homicide determined 28e. Place of Injury building, etc. (3)										
29a. Certifier Check only 2 Medical Examiner: On the basis of example one) 29a. Certifier 2 Medical Examiner: On the basis of example one) 29b. Signature and title of certifier	ramination and/or in	vestigation, in my opi	nion, death occurre	ed at the time, date	e and place, and due	to the cause(s)				
TETE S 20h Cierostum and title of analytics		29c. License			I. Date signed (Mont)					
The things	cel no	Do5	7936	(111001	2006				
30, Name and address of person who completed cause of death	h (Item 23a) (Type,	Print) Ave. Bo	7936 altima	e, mo	21229.	2006				

Please Type or Print in Black Indelible Ink. Er	insure All Copies Are Legible.
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		For State Registrar	State	of Marylar		ertment of H tificate of I	lealth and N Death	-	giene 006	00189
Physici		Decedent's Name (First, Middle, F.)		Helene	Garey			2. Date of De Month	Day Yea	3. Time of Death 6:40 P
/Medic Examin		4a. Facility Name (If not institution, Gilchrist Nursi	-			4b. City, Town, or TOWSC	Location of Death		4c. County of De	
Funeral Director		5. Social Security Number 219-07-9080	3. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 85	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da April	y, Year)	Birthplace (State or Foreign Country) aryland
and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Loc	cation				10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show Finant to rediffed at	tor	M . 3 3 70-3	L-1				Dundal:	l-		1 ☐ Yes 2 🔣 No
r 28a	Director	Maryland Bal 10e. Street and Number	timore			10f. Zip Code	Dundan	V	10g. Citizen of What	Country?
23a o	al D	1779 Brookviev	Road				21222		United	States
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inportant: if tem 27 is marked other than "natural; or tems 28a or 28a-1 ehow any Injury or other traumatic event, the Medical Examination must be retified at once.	by Funeral	11. Marital Status 1 Never Married 25 Married 3 Widowed 4 Divorced	Armed F	2 ∑ No ive		Vas Decedent of H Yes, specify Cuba ☐ Yes 22 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 14. Race - Ai Black, W Specify:	merican Indian, hite, etc. White
2 hou		15. Decedent's	Education		16a. Deced	ent's Usual Occup	ation		16b. Kind of Busine:	
ithin 73	Completed	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	(Give life. L	kind of work done of OO NOT use retired	during most of work f)	king	Baltimore	
iled w dygier ther th		10 Years 17. Father's Name (First, Middle, L	acti		Т	elephone		o (First Middle	Papers Maiden Sumame)	
d be f ental h	o Be	Wallace L. Bat						re Fiscl		
shoul nd Me mark umati	2	19a. Informant's Name/Relationshi		Husband	19b. Mailin	g Address (Street a			er, City or Town, State	e, Zip Code)
and 2 alth a 27 to er tra		Mr. Charles L.	Garey, S	Sr.	1779	Brookvie	ew Road	Dundalk	, Maryland	. 21222
of He of He if Item or oth		20a. Method of Disposition 12 Burial 2 Cremation	3 DRemoval from		Place of Dispos	sition (Name of natory or other place	(8)	Date	20c. Location - City	or Town, State
Pag tment tant: I		4 ☐ Donation 5 ☐ Other (Spe	ecity)	Pa		Cemetery				re, Maryland
permit Depart Impor any In	e b	21. Sign ture francial rvige L	Fully		79	922 Wise	Ave. Du	ndalk, N		Inc. 21222
		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that nly one cause on	caused the dea each line.	th. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	nd sn	age n	enal d	iscase			Onset and Death UCVS
/Medical Examiner		rosulting in doatily	Due to	(or as a consec	quence of):		-			
a Torr	er	Gequentially list currentions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	r as a consec	quence of):	court	~,			4643
outed ansit	Examiner	that initiated events	c							
ficate be executed physician and s the burial-transit	Exe	resulting in death) Last	Due to	(or as a consec	quence of):					
cate b physic the b	edical	•	d							
Hospital or Attending Physician: The law requires that the death certifithours after death. Funeral Director: After this certificate has been signed by the attending leif filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 inonths? 1 □ Yes 2♥ No 9 □ Unknown	1 ☐ Live	itcome of pregn birth 2 ☐ Feta nant at time of d nown	aldeath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
uires that n signed b	þ	Part II. Other significant condition	s contributing to d	leath but not res	sulting in the un	derlying cause give	en in Part I.		obacco use contribute	to the cause of death? Probably 4 Unknown
haw recinas been	Completed							24a. Was	an 24b. Were	autopsy findings available o completion of cause of
: The								perfor 1 ☐ Yes	med? death	? es 2□ No
slcian certif rector	Be	25. Was case referred to medical examiner?	Hospital:		1	Othe	26. Place of Deat		10	
g Physer this eral d	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. Injun	4 Nursing Ho	ome 5 ☐ Resid	lence 6 Other (Sp low injury occurred	pecity) MOSPICE
ath. r: Afte	atlo	1 Anatural 5 ☐ Pending 2 ☐ Accident investiga		nth, Day Year)	Injury		k? Yes 2 □No			
r Atte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 289. Place	e of Injury - At h ling, etc. (Speci		eet, factory, office		28f. Location (S City or Tow	Street and Number or and	Rural Route Number,
urs at urs at eral D		20. O. W								
	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E.	xaminer: On the b	e best of my kno pasis of examina iner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my of	ne, date and place, pinion, death occurr	and due to the or red at the time, or	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. License			29d. Date signed (Mo	· · ·
10		* Att	and	~ M	D	D	58303	3	January	6 2006
5 /		30. Name and address of person w	URS WN	6601	N-Cha	2621 SMR	EET 1	Satin	we mo	21204
Sta Registr		31. Date filed (Month, Day, Year) JAN 0 9 20	32. F	Registrar's Sign	ature	and the second				1

Patient from as Hughes Ardie Baltimore, Maryland 21215-0036

Records, P.O. Box 68760.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Archie Hughes, Jr. January 200 4 600P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimere City Baltimore Hospital of N/A)inai 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 ☐ F 240-40-5140 Yrs 70 Director Jan.6,1935 \$.Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show N/AMaryland Baltimore Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 5408 Gist Avenue 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2€ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married ò 1 ☐ Yes 2 ☒ No Spec Black þ 3 Divorced 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry le marked other then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Custodian Pratt Library 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Archie Hughes, Sr. Mattie Burris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 le any Injury or other trau 5408 Gist Avenue Baltimore, Maryland 21215 Elizabeth Hughes/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 1/7/06 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Maryland 21. Signature of Funeral Service Lice yee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) entral **Physician** Cord Syndrome with 2 months /Medical Due to (or as a consequence of). Examiner our light Equantiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physiclen: The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical the as attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has certificate 2 1 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1¥Yes 2□No ٩ 1 Nnpatient 2 ER/Outpatient 3 DOA uis After this funeral of 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation s after dec. 1 Natural 1 Yes 2 No 2 Accident 800 Vovember 3,2005 Fell Lown Stairs b

281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 5406 fist Avenue within 24 hours a To the Funeral C filled Home. Baltimore MD 21215 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D 63282) anuary 1 12006 completed cause of death (Item 23a) (Type, Print) Sirai CelianValeno 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 09 Registrar 2006

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M		epartment of l Certificate of			giene Reg. No. 006	00191
	Dhyalai	€ .	1. Decedent's Name (First, Middle,	Last)				2. Date of Dea	Day Y	3. Time of Death
	Physici /Medic		Patricia			Holmes		JANUAR'	Y 5, 200	
	Examin	er	4a. Facility Name (If not institution, g Saint Joseph				or Location of Dea	on		Death ltimore
	Funeral		5. Social Security Number 6	. Sex 7. Ag 1 ☐ M 2 🛱 F	e (In yrs. last birth	day) If Under 1 Year Months Days			y, Year) 9.	Birthplace (State or Foreign Country)
Car.	Director		216-42-2919 Usual Residence of Decedent	X	61	3.		10-1	11-44	Md.
	/land low		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Man	tor	Md. N	IA.		Baltimore				1 XYes 2 □ No
	r 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	th wit	ai D	807 Arnold Cou	rt		2	1205		USA	
	dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent of	Hispanic Origin? (Specify Yes or No-	14. Race -	American Indian, White, etc.
9	or It	y Fu	1 Never Married 2 Married			1 ☐ Yes 2 ☐ No		nto i noun, oto.,	Specify:	
8	ural',	d by	3X Widowed 4 □ Divorced	Year or Dates:						Black
7	be filed within 72 hours after death with the Maryland ital Hyglene. d other then "natural", or Itams 23a or 28a-f show event, the Madical Exeminar must be notified at	Completed	15. Decedent's (Specify only highest			Decedent's Usual Occu Give kind of work done life. DO NOT use retire	during most of we	orking	16b. Kind of Busin	ess/Industry
7	withi ene. then	шć	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Co-Manag			United I	Retail Corp.
ე ე	filed Hygi sther		11th grade 17. Father's Name (First, Middle, La	st)		oo nanag		me (First, Middle,		Retail Corp.
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Itam 27 Is marked other then "natural", or itams 23a or 28a-f show other traumatic event, the Madical Exeminar must be notified at	To Be	Unkn				Romona		Sander	re .
ary	should ind Men ind Men in marke	_	19a. Informant's Name/Relationship	(Type, Print)	19b. I	Mailing Address (Stree		lural Route Numbe		
	and 2 salth a n 27 ls		Lisa M. Porter	Dau	ghter	807 Arnold	Court, I	Paltimore	. MA. 21	205
ore			20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other pla		Date	20c. Location - Cit	
altimore,	Pages ment of I ant: If Its ury or o		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		Balti	more Cem.	1-1	L3-06	Baltimor	ce, Md.
alt	permit. Page Department of Importent: If any Injury or once.		21. Signature of Funeral Service Lic	ensee		22. Name and Addre	ess of Facility	Balt	imore, Mo	1. 21202
<u></u>	207 2 2		Blad	y War	nen	March F.	H. East	1101	E. North	Ave.
3/			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each li	d the death. Do no ne.	t enter the mode of dy	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
خېل	Physician		Immediate Cause (Final disease or condition resulting in death)	a METAST	ATIC OV	ARIAN CAN	ICER			Criser and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):				
2 4	A. 160	-	Sequentially list conditions,	b. — Jue to for as	a consequence of					
	ned ned	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0. 00	2 201103 4221100 01	,.				
<u>,</u>	execun and and ial-tra	Exai	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):				
8760	icate be executed physicien and s the burial-transit	dicai		d.						
9	tificat ig phy as th	a								
ŏ	feath certific attending p	N/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal death	3 ☐Ectopic pregnanc	27		23d. Date of	f delivery
m	the att	sicie	in the past 12 months? 1 Pyes 2 No	4☐Pregnant at 9☐Unknown		5 Other (specify)	·y		Month	Day Year
0	that the dead by the detached	Physician/M	9 Unknown							
Records,	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions SEPSIS	contributing to death b	ut not resulting in t	he underlying cause gr	ven in Part I.	23e. Did to		te to the cause of death? Probably 4 Unknown
ဝ၁	e law re has be	Completed	LACTIC ACIDO	SIS				24a. Was a		e autopsy findings available
_		mo:	RENAL INSUFF	ICIENCY				autops perfor	med? deat	r to completion of cause of h? Yes 2 No
Vita	ysician: is certifice director, p	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only or		
<u>></u>	Physic this ce al dire	2	1 ☐ Yes 2 X No	Hospital: 1 X Inpatie		atient 3 DOA Ott	her: 4 Nursing	Home 5 Resid	ence 6 Other (Specify)
Division of	ding F	Certification:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Inju (Month, Da	ry 28b. Tin y Year) Inju	ury Wo	ryat ⊮k?]Yes 2∐No	28d. Describe h	ow injury occurred	
Divis		ertific	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Inj building, et	ury - At home, farm c. (Specify)	n, street, factory, office		28f. Location (S. City or Town	treet and Number on, State)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled		29a. Certifier 1 Certifying	Physician: To the best aminer: On the basis of	of my knowledge,	death occurred at the ti	me, date and plac	e, and due to the c	ause(s) and manne	or as stated.
	the hin 24 the F	Medical	One)	and manner sta	318G.					
	or with	-	29b. Signature and title of certifier	. 1 1.	I W	NO 29c. Licens		2	9d. Date signed (N	
h			1 Sichar	f L. Lui	Thicking	D318	326		1-5-	06
/	/		30. Name and address of person wh	o completed cause of d						
	Sta	te	RICHARD LIN' 31. Date filed (Month, Day, Year)	32. Abgistr	D. 761 ar's Signature	A1 OSLER	DRIVE	TOWSON,	MARYLAN	ID 21204
	Registr		JAN 0 9	2006	ar's Signature	Sports.				

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. Amend 1tems 5,15,20b per fh g851 1-13-06 vt. State of Maryland 7 Department of Health and Mental Hygiene 1 6 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jan 8, Anna O. Horner 2006 9:00P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Morningside House Of Friendship Hanover Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
April 30,1921 5. S220-07-15806 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours Min 1 □ M 2 🙀 F 219-01-3482 Director 84 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Mo4e ir than "natural, or items 23a or 28a-f ehor the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel MD Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6950 Ridge Rd 21076 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White δ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental H 7 is marked ott Anna M Thalheimer Joseph Spetzler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar Important: If Itam 27 is eny Injury or other trau Anna M Browne Daughter 21076 6950 Ridge Rd, Hanover MD 20b. Place of Disposition (Name of cemetery, exematory or other place) 17^{Date} 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 1-10-06 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Euheral Seniese Licent ²Fink art Address of Facility one, P.A. MO1148 426 Crain Hwy, SW, Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. E ter the disease shock, or leart fail re. I r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to my one cause on each line. Immediate Caus (Final disease or condition resulting in death) 0 Physician ear /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit by the attending physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? À 2 ☐No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 Ho 1 Yes 2110 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Distatural 2 Accident 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred al or Attending P safter death. I Director: After d in by the funera After 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funaral Di Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) em 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32/ Re

9 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Physician January 7, 2006 Magda Vanek Humphreys 1:41 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Charlestown Care Center Catonsville Baltimore | Months | Days | Hours | Min. | Feb. 23, 1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 M 2 KF Yrs. 099-16-3667 Director 84 Romania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28e-1 ehow any hijury or other traumatic event, the Medical Exemples. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 707 Maiden Choice Lane #8103 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Travel Agent 12 Trave1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Vanek Irene Lazslo 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard G. Newton Box 503; Centerville, Utah 84014 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 1/9/06 Metro Crematory Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice see 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Medical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Known Hepatitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 IN 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. fnjury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D44377 Dowling MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21228 Choice Lane, Catonsville, mo Bowlin, MD 711 Maiden 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JANO

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 4, 2006 **Physician** ROGER REINHARD HETZNER 1:20A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 30, 1921 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral X**X M 2□ F Yrs 214-18-9871 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City Town or Location permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or Itema 23a or 28a-f ehow eny injury or other traumatic event, the Marical Examiner mast be notified at once. 10d. Inside City Limits XIXXYes 2 No Directo Maryland | N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 E Melorse Avenue 21212 IISA 12. Was Decedent Ever in U.S. Anned Forces?

XXIYes 2 □ No WWII I If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X XIo Specify: White ģ XXWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wholesaler Florist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Reinhard Hetzner Effie Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Hetzner Biddison DTR 5609 Purlington Way Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 1/7/06 Pikesville, Maryland ignature of Funeral Service kicens 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. Onnis D 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancer months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, I any leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dies to for as a consequence of Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed IETHEN, KAGEN Division of Vital Recor 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔁 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Naspiel 1 ☐ Yes 2 🗖 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funerel D 29a. Certifier 🛌 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause si and manner as stated 2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Cneck only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CWS January 4 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wills for American mo 2/2024 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

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- Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 13-16-3924 1X M 2 F 85 Yrs. Hours	Min.	Date of Birth (Month, Day, Jan. 15	Year) 9 5,1920	. Birthplace (State or Foreign Country) Maryland
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Z1Z13-UU36 4 within 72 hours af piene. r then "natural", or the Medical Exemple.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 Years 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired) Systems Analyst		1	6b. Kind of Busin Interna Servic	l Revenue
aryland Z should be filed and Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last)	er's Name <i>(F</i> rie Kr		laiden Sumame)	
and and le man		19a. Informant's Name/Relationship (Type, Print) Mrs. Hannah G. Hemelt (Wife) 7737 Wynbrook Road				
Saltimore, IN Department of Health Important: If Item 27 Any njury or other tr		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Ht. of Jesus Cer	Date m. 1/9		Oc. Location - Ci	
Baltimo permit. Page Deportment Important: If any njury or		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funes 7922 Wise Wise	ral Ho	ome of :	Dundalk,	Inc.
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te be executed ysician and burial-transit	ical Examiner	d		DAYS		
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	Completed			24a. Was an aulopsy perform 1 Yes 2,	prio led? dea	re autopsy findings available or to completion of cause of th? Yes 2 \(\subseteq \text{No} \)
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10+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RATIMORE RATIMORE	E, 1	MARYL	AND	4, 4, 2006 21224.
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-	/Medio	12.	4a. Facility Name (If not institution, give str				4b. City, Town	o, or Locat	ion of Death	Janua		2006 County of Dea		30PM "
	Funeral Director		1221 Ridgeshire Ro 5. Social Security Number 6. Sex 212-34-3372		e (In yrs. last	birthday) Yrs.	If Under 1 Ye Months Da		der 24 Hrs.	8. Date of Birt (Month, Da)	y, Year)	9. Bi		e tate or Foreign Carolina
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Maryland 21215-0036	i within 72 ho liene. r than "natur Ine Medical	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) 12 Years	ition completed) College (1-4or 5		(Give :	ent's Usual Oc kind of work do OO NOT use re ness Ow	ne during i rired)	most of work	ing	16b. Kind of Business/Industry HOOVER'S Liquors			
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Baltimore,	permit. Pages 1 and Department of Healt Important: if item 2 any injury or other once.	4 □ Dopation /5 □ Other (Specify) 21. Signiture (Funeral Service Licens 22. Name and Address of Facility Duda - Ruck Funeral							acility		Dung	ltimore		cyland
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P.O. Box 6	Physician: The law requires that the death certific this certificate has been signed by the attending p rat director, page 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pregna Other (specify				2:	3d. Date of de Month	elivery Day	Year
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Division of Vital Records,	: The law re cate has bee page 2 sho	Completed								24a. Was a autop perfor	sy	24b. Were a prior to death?	completion	ings available of cause of
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	To the Hospital within 24 hours a To the Funeral a completely filled	Medicai	29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	cian: To the best or: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the estigation, in m	time, date y opinion,	e and place, a death occurr	and due to the d ed at the time, d	ause(s) a date and p	and manner a place, and du	s stated. e to the cau	use(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item / per fh 9851 1-17-06 vt.
State of Maryland / Department of Health and Mental Hygiene () () (5 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2006 Daniel John Hepburn, Sr. January 5:23 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Towson Gilchrist Hospice Center 7. Agenty yrs. last birthday)

Months Days Hours Min. April 8, 1916 5. Social Security Number Birthplace (State or Foreign Country) 1 🗶 M 2 🗆 F 217**-**07-0291 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore Towson Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21286 305 E. Joppa 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Sheet Metal Mechanic 9th grade College (1-4or 5+) Heating & Cooling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Walker Richmond George Leo Hepburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George R. Hepburn Son Severna Park, MD 21146 1 Cedar Point Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 01/10/2006 Parkville, MD Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Service LicenseeCharles Miner 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 abe, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y. List only one cause on each line. 23a. Part1. Enter the disea shock, of heart failure Immediate Cause (Final Approximate Interval Between Onset and Death Carncer disease or condition resulting in death) Due to (or as a consequence of): YENS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? IVYes 2□No 3□Probably 4□Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other (Specify) No Pul 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation М 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 2006 1)58303

Physician /Medical Examiner Box 68760, Ö of Vital Records, Hepburn, Davie

Physician

/Medical

Examiner

Funeral

Director

rai', or itema 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death neat of Health and Mental Hygiene.
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Department of Important: If any injury or once.

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Baltimore, Maryland 21215-0036

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within 24 hours after d To the Funaral Direct completely filled in by

parte

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

And Charles my Charles I. Charles S.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JAN 0 9 2008

ADH ROBERT LEE HARDY, Sr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-0152 State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** JANUARY 3, 2006 1910 РМ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1818 N. FULTON AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 150M 20F Yrs. N.C. 237-64-0145 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Xes 2 □ No Director Ma 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1818 21216 HUENKE 54 LIOR Funeral 12. Was Decedent Ever in U.S. Armed Forces?, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 X No fYes, Give fear or Dates: 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 Yes 2 No Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 10th Custodian 4470 permit. Pages 1 and 2 should be filed Deperment of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be colara Hurdy Hurdy Christain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Lift 20a. Method of Disposition Dolp Li Hardy 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Park Januar 7, 2006 4 □ Donation 5 □ Other (Specify) a Mem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W Lie 638 N. Gilmor Street BATTime, and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): Physician/Medical ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à DIABETES MELLITUS 2 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performęd* this certificete 2 No 1 ☐ Yes 1 Yes 2 No Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence (**) Other (Specify) SCENE 2 1 XYes 2 □ No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending М 1 TYes 2 □ No investigation hours efter death 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours t To the Hospital

Registrar DHMH 17 Rev 1/2001 29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who

JAN 0 9

31. Date filed (Month, Day, Year)

Medical

State

completely

ORIGINAL

completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

PAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

OCME

29c. License number

29d. Date signed (Month, Day, Year)

JANUARY 7, 2006

111 PENN STREET, BALTIMORE, MARYLAND, 21201

State of Maryland / Department of Health and Mental Hygiene 🕦 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 01/02/2006 **Physician** Year Joseph Stephen Jackowski 10:10A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Severna Park

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Genesis Eldercare Anne Arundel 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1⊠M 2□F Yrs. 12/14/1918 Director 219-05-8206 87 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits in then "neture!", or flems 23a or 28a-f show the Medical Exercine must be notified at 1 ☐ Yes 25 No Director Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1656 Wall Drive 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 0 2 11. Marital Status Amiled Forces?
1 ⊠Yes 2 No 1939.
If Yes, Give Year or Dates: 1945 e filed within 72 hours after all Hygiene.
other then "neture!; or itel 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: <u>م</u> White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: If item 27 is marked other th any injury or other treumatic evant, ILLA ODGE. 2 Linotype Operator Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Jackowski Mary Grabaski 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) Stella Jackowski Wife 1656 Wall Drive, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veteran's Cem | 01/06/06 | Crownsville, MD `4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G. J. Gonce Funeral Home, PA 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examiner attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1)ZiYes 2□No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 🗆 Yes 2 No 1 ☐ Yes 25 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ②XNo 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 5 Pending investigation ► Natural M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide TX Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3rd 51596 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 Vakwood K. Ambalaranar Road, 103. Glen Burne 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 9 2005 Registrar

Certificate of Death

21205

Specify:

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26. Place of Death						
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Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

address of person who completed cause of death 0 LH04

32. Registrar's Signature

ORIGINAL

State Registrar

31. Date filed (Month, Day,

State of Maryland / Department of Health and Mental Hygiene 006 Certificate of Death

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/Medical	
Evaminar	

Funeral Director

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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er	4a. Facility Name (If not inside 3480 Spelman		treet and numb	91')		4b. City, Town, o Baltimor		atri	4c. 0	ounty of Deat N/A	n							
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Funeral Director			12. Was Decede Armed Force 1 ☐ Yes 23 If Yes, Give	s?		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ★No	ispanic Origin? in, Mexican, Put Specify:	(Specify Yes or No erto Rican, etc.)		4. Race - Ame Black, White	e, etc.							
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To Be C	17. Father's Name (First, M	17. Father's Name (First, Middle, Last) Charles A. Jones						ne Brow		Gumame)								
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	20a. Method of Disposition		emoval from Sta	ute C	emetery, crei	rmel Ce	1 1 2	n,11,06		ation - City or ltimor								
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	29b. Signature and title of	certifier	`			0.C.1	O.C.M.E. January 02, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
	30. Name and address of p	person who co				Print)					2006							
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	30. Name and address of p	person who co	1 J2. Rate		1 Penn	Print) Street,					2006							

State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JANUARYPAY6, ZONG Physician Bernard William Joyce 7:38P /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner OWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. 17, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**⊠**M 2□F Months Days Hours Maryland 216-18-4634 81 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "naturel", or items 23s or 28s-f show the Modical Exeminer must be natified at Maryland Catonsville Baltimore 1 ☐ Yes 2X No Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1909 Westchester Avenue 21228 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ՃYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Diverced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) 6th Machinist Coast Guard Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be for and Mental P . Pages 1 and 2 should be thent of Health and Mentatent: If Item 27 is marked James J. Joyce Elizabeth Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 1909 Westchester Avenue; Catonsville, MD 21228 Mary Jane Joyce 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 1/10/2006 Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland 22 Name and Address of Facility Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Liounsee 1630 Edmondson Avenue: Catonsville. 21228 Part Enler the disease of complications that the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA OF THE LUNG Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physician had for use as the buria Completed by Physician/Medical the use as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed yes 2 this certificate 1 ☐ Yes 1 Yes completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending after death. investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours aft To the Funeral DI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 01-06-06 D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 32. Angistrar's Signature 31. Date filed (Month, Day, Year) Course State JAN 0 9 2006 O Soll state of Registrar

06-0082 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,PII,27,perMF,C852,2///06 IT State of Maryland / Department of Health and Mental Hygiene B.K.S RICHARD JOHNSON For State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Richard Yarborough Johnson JAN. 2006 1830 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4000 COASTALHIGHWAY OCEAN CITY Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) February 2, 1953 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours XX M 2□ F 215-60-5981 52 Mařÿïländ Yrs. Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ehov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√√ No Completed by Funeral Director Maryland Worcester Ocean City the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4000 Coastal Highway #110 21842 USA or itams 23a death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes (M) No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Supervisor Construction 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Elmer Yarborough Johnson Mary Jean Goldsmith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guy Lummis Brother 8102 Aspenwood Way Jessop Maryland 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 200 Cremation 20c. Location - City or Town, State 3 Removal from State GreenMount Cemetery 1/7/06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funer Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Complications of Liver Cirrhosis Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner attending physiclen and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 4 Dinknown Hypertensive Cardiovascular Disease 1 ☐ Yes 2 ☐ No 3 Probably should 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No page 2 s autopsy performed? 1 X Yes 2 No Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE 1X Yes 2 □ No Certification: To 2 ER/Outpatient 3□ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After aspital ...
4 hours after dea...
...ai Director: Afr 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

And medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Fune Within 24 (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E JAN. 4, 2006 eath (Item 23a) (Type, Print) 30. Name and address of person who completed cause of 111 PENN STREET, BALTIMORE, MARYLAND 21201 MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

JAN 0 9

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 00206 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** JANUARY 8:27 AM CHARLES HAMSTRONG KENNY 04 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE HARBOR If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 100M 20 F Days 214-24-6928 Yrs. Director MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinat must be notified at 1 Nes 2 No Director TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? <u> 215</u> 21225 UNITED by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ☐ Widowed 4 MDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Federation for the blind Elementary/Secondary (0-12) College (1-4or 5+) JANITOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES A. KENNY DKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is m any injury or other traum ance. AVE BALTIMORE, MD 21705 215 TOWNSEND GEORGE LINK 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/06 HANOUER, N ANATOMY GIFTS REG. 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee DINTONY GIFTS REGISTRY 7500 CONVERCE DRIVE HONOGREMO 31076 > 1 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) MASSIVE Physician CEREBROVASCULAR /Medical Due to (or as a consequence of): Examiner NON - ST ELEVATION MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit certificate be executed OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of) ettending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2X No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 28 No 1 K Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 SNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P19595 JANUARY 04 2006 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person S. HANOVER ST. DHIRAJ BALTIMORE MD 3001 JA GASIA M.D. 31. Date liled (Month, Day, Year) 32 Registrar's Signature State 9 2006 JAN 0 Care Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend item 19a per in 851 1-10-06 vt
State of Maryland / Department of Health and Mental Hygierie | | | | | |

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 8:14 а м Kearney J. Lewis 01 04 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dorchester House If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 10 06 13 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**X** M 2□ F 92 Yrs. Director 244-05-3638 Usual Residence of Decedent with the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic ayant. The Medical Examiner must be notified at 1 Yes 2 ☐ No Director Baltimore MD NΑ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Itams 23a 21215 U.S.A. Completed by Funeral 2712 Uhler Ave death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify: **%** Widowed 4 □ Divorced Specify: Black "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Tobyhanna Signal al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Packer Depot 6th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I James Walter Kearney Hattie B. Kearney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Itam 27 is any injury or othar trainonce. Cecelia Corley Daughter 2712 Uhler Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State * 4 ☐Donation 5 ☐ Other (Specify) King Memorial Park 1/9/05 Randallstown, 21. Sign ur of Funeral Service Lin nsee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Buter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cairfea Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. the 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed nemea 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate has 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Assition examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No this eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner 28d. Describe how injury occurred After 5 Pending investigation 1 tural Injury 1 ☐ Yes 2 ☐ No 2 Accident death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. tha 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 Usperai MI) 11612006 126748 30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) ROBALTOMDOBIL MD Les Este s 419 1= ALLS ANIL 4 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State JAN 0 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygier 📔 🕦 🕤 1 - Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY Lucille Anne 2006 10:30P M Kowalski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | December 13,1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M XXF Mary and 213-14-9450 86 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f ehow Executer rount be notified at XXYes 2 □ No Completed by Funeral Director N/A Maryland| Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3837 Loch Raven Blvd 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes XXNo White Specify. 3 ☐ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Clerk Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Stephen Kowalski Mary Ushler ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health as Important: If Item 27 Is any Injury or othar trau Florence V Stallo Sister 3837 Loch Raven Baltimore Maryland 21218 20a. Method of Disposition

XXBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Holy Rosary Cemetery 1/18/06 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Maryland Signature of Funeral Segrice Licenses 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEUMONIA 3 DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the ettending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation deeth. 1 Tes 2 No completely filled in by the Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D25886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 ILIA CEBALLOS OSLER DRIVE, TOWSON, MARYLAND 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene []

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			1 - State Registrar		C	ertificate of	Death		Reg. No.		Ç 🔾 📖 .		
1	t es		Decedent's Name (First, Middle, L.	ast)				2. Date of De	ath		3. Time of Death		
	Physic		EUN BOK KIM					7 4, 20	Year	6:05 A. M			
	/Medi Examir		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town,	or Location of Deatl	4c. County		10:05 A.			
		χ	STELLA MARIS			TIMON					r		
	Funeral			Sex 7. Age (In yrs. last birthda	ast birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplac							
32	Director		215-23-0994 Usual Residence of Decedent	1 □ M 2 □XF	33 Yrs.	Months Days	Hours Min.	8/28/1	y, Year) 1922	Cour	TH KOREA		
	ylanc Now		10a. State 10b. County	1	Oc. City, Town or	Location				1	10d. Inside City Limits		
	e Mar	ctor	MD BALTIM	ORE	TOWSO	ON					1 ☐ Yes 2 💢 No		
	th with th	ai Director	10e. Street and Number 22 MAYAPPLE COU	RT		10f. Zip Code	1286		10g. Citizen of SO	What Cour	-		
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Iteme 23a or 28a-1 ahow avent, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	er in U.S. 13	B. Was Decedent of If Yes, specify Cub	an, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Rad	can Indian, etc.			
2000	72 hg	tec	15. Decedent's E (Specify only highest gi	ducation	16a. Dec	edent's Usual Occu	pation	tina	16b. Kind of B				
	d within grane.	Completed	Elementary/Secondary (0-12) 8TH GRADE	College (1-4or 5+)		re kind of work done DO NOT use retire MEMAKER	during most of wor	king	OWN HOME				
	al Hygie I other	Be (17. Father's Name (First, Middle, Las	")			18. Mother's Nan	ne (First, Middle,	Maiden Suman	ne)			
	should be nd Mental marked o	To	UNAVAILABLE			<u> </u>		AILABLE					
	0 0 0		19a. Informant's Name/Relationship			iling Address (Stree		ral Route Numbe	er, City or Town,	State, Zip	Code)		
	f Health item 27 other tr		JOYCE AHN/GRANDD	AUGHTER	22 M 20b. Place of Dis	IAYAPPLE C	COURT TO	VSON, MD					
	00-		20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 [Removal from State	cemetery, cr	ematory or other ola VALLEY ME	ce)	Date	20c. Location -	City or To	own, State		
			4 Donation 5 Other (Spec		GARD	ENS	1/0/		COCKEYS				
	permit. Pag Department Important: any Injury c		21. Signalure & Funeral Service Lice	N. Hay		22. Name and Address 8521 LOCH			ON FUNE WSON, M		IOME, P.A. 286		
漢 ()	Physician Medical Physician and Medical Examiner	Examiner	23a. Part 1. Enter the disease, or confock, or heert failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	_	ensequence of):	re vas	20/32		de e		Interval Between Onset and Death		
	ate be hysicië the bu	Ical		_ d									
	ath or u	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ M0 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y			te of delive	ery Day Year		
	res that the de signed by the a be detached t		Part II. Other included conditions	contributing to death but r	not resulting in the	underlying cause an	ven in Part I.	23e. Did to	obacco use cont	ribute to th	ne cause of death?		
	quires n sign aid be	d by	MECONE W	14					res 2□No				
	0 5 0	Completed	Old sly	oles				24a. Was autop	sy p	Were autor prior to cor death?	psy findings available appletion of cause of		
	ician: Th certificate rector, pag	Ö	25. Was case referred to medical	V-nic				1 ☐ Yes	NO 1	I ☐ Yes	2□ No		
	ysician: is certific director.	o B	examiner?	Hospital:	a∏ ED/0 :	Ctt	26. Place of Dea						
	Phys r this ral di	-	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie	ant 3LIDOA	Nursing H	ome 5 Resid	dence 6 Oth-		1)		
	r Attending Physician: or death. rector: After this certific. by the funeral director.	Certification:	Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	(Month, Day Y	ea <i>r)</i> Injury	M 1							
	2 9 E C	Certif	4 ☐ Homicide determined	building, etc. (Specify)	reet, factory, office		City or Tow	Street and Numb vn, State)	er or mura	I Houte Number,		
	To the Hoepital or within 24 hours afte To the Funeral Dir completely filled in	Medical (29a. Certifier Check only one) Certifying Pl	nysician: To the best of n niner: On the basis of ex and manner stated	amination and/or i	ith occurred at the til nvestigation, in my o	me, date and place, printon, death occur	and due to the d red at the time, d	cause(s) and ma date and place, a	nner as stand due to	ated. the cause(s)		
	To the To the comp	M	29b. Signature and tille of certifier	lasti.	25	29c. Licens	e number	£ .	29d. Date signed		Day, Year)		
			30. Name and address of person who EDDIE NAKHUDA, M.				TIMONIUM	, MD 210	093				

State Registrar

31. Date filed (Month, Day, Year)

JAN 9

6:05 A.M.

JANUARY 4, 2006

32. Registrar's Signature

2006

			1 - For State Registrar	State of Maryl		artment <i>rtificate</i>			d Mental	Hygier	ZU!	06	0020	8
			1. Decedent's Name (First, Middle, Las	st)					2. Date	of Death	Day	V	3. Time of Deat	th
300	Physici /Medi		Betty	Jean	Lan	bert				uary	l	2000	1054	łм
	Examir	ner	4a. Facility Name (If not institution, give	11 -1 1			cation of De			y of Death				
		**	5. Social Security Number 6. S	HOSPITAL	rs. last birthday)	If Under		MO FE		4	N/			
	Funeral Director			□ M 2 🖾 F 69	Yrs.	Months		Hours M	in. Dec.	of Birth h, Day, Yea 1, 1	936	Cour	place (State or Form ntry) Virgini	
ent.	ס		Usual Residence of Decedent			L			Dec.	1, 1		West	VILGIIII	d
	nrylan show	_	10a. State 10b. County	10c.	City, Town or Lo	ocation						1	0d. Inside City Lin	
	Se-f.	cto	Maryland N/A		Baltimor								₽☐Yes 2☐	No
	with th	5	10e. Street and Number	1 T		10f. Zip						What Cour	ntry?	
	eath	erai	821 North Chape	12. Was Decedent Ever in	0118 13		229	nio Origin?	(Casady Vas		USA	00 A	an Indian	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ahow any fulury or other traumatic event, the Medical Example or must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever II Amed Forces? 1 □ Yes 2X No If Yes, Give Year or Dates:		was Decede If Yes, speci	fy Cuban, I	anic Origin? Mexican, Pu Specify:	(Specify Yes of erto Rican, etc.)	or No- :.)		ce - Americ ick, White, fy: Wh		
20	72 ho	ted	15. Decedent's Ec (Specify only highest gra		16a. Dece	dent's Usual	l Occupatio	n ng most of w	undking.	16b.	Kind of B	Business/Ind	dustry	
7	ithin ser.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	e retired)	ng most or v	vorking					
2	led w tygier her th		12		Se	xton					Chu			
Maryland 21215-0036	id be fi ental F ked ot ic ever	To Be	17. Father's Name (First, Middle, Last) William Lar	wrence	Wolfor	d		Lillia	lame <i>(First, M</i> . 1 n		_{en Sumar} dith	me)	Fultz	
lary	and Marks marks and Marks marks and Marks and	-	19a. Informant's Name/Relationship (уре, Print)	19b. Mailir	ng Address	(Street and	Number or	Rural Route N	umber, City	or Town	, State, Zip		
≥,	and ealth m 27 her tr		Thurman N. Lambe		821 N	orth (Chape.	lgate	Lane,					
Ore	Pages 1 nent of H ant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	b. Place of Dispo cemetery, crer	natory or oth	her place)		Date			- City or To		
Baltimore,	t. Partmen		4 □ Donation 5 🖾 Other (Specify	EntombmentLo				1	-	1			aryland	
Ba	Depa Impo any ir		21. Signature of Funeral Service Licen	seo					oudon, Balt					
	E-VIII		23a. Part1. Enter the disease, or comp	olications that caused the d							,		Approximate	
	Physician		shock, or heart failure. List only immediate Cause (Final disease or condition	one cause on each line.	EPSIS								Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):			-					20195	
	- Xariiliei	35	Sequentially list conditions,	b. Due to (or as a cons	ATED	CARDI	0 my	OPATH)				montus)
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		HEMIC	. BO					Days	4		
oʻ	en an erial-tr	Еха	resulting in death) Last	Due to (or as a cons	sequence of):							-	Dave	
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		/Me	IF FEMALE:											
P.O. Box	that the death certifi ed by the attending detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ectopic pre Other (spe						ld. Date of delivery Month Day Year		
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Division of Vital Records, I	The law requires that the death certifi site has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions or	ontributing to death but not	resulting in the u	nderlying car	use given ir	n Part I.		Oid tobacco		tribute to th	e cause of death? ably 4 M Unkno	
ecc	ne law re has be ge 2 sho	Completed								Was an	24b.	Were autop	osy findings availal	ble
<u>=</u>	The cate h	Con							1 🗆 Y	performed?		death? 1 🗌 Yes		,,
Zi Zi	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Magnital:			1		eath (Check o					
5	Phys this ral dir	2	1 Yes 2 No 27. Manner of Death		ER/Outpatien		d Other:	4 🗌 Nursing	Home 5 1)	
o	ding th. After funer	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) Injury	M 20	ic. Injury at Work?	2 🗆 No	280. Desci	ibe how inj	ury occur	rea		
S ×	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre				28f. Locati	on (Street a	and Numb	er or Rurai	Route Number,	
	oitet o urs att oral Di												•	
	Hosp 24 ho Fune etely fi	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	rsician: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at restigation, i	t the time, o	date and place on, death oc	ce, and due to curred at the ti	the cause(me, date a	s) and ma nd place,	anner as sta and due to	ated. the cause(s)	
	Vithin Fo the		29b. Signature and title of certifier		rodical	√ 29c.	License nu	mber		29d. D	ate signe	d (Month, L	Day, Year)	
			> physiloga	nnathan (esident	1	186	08		170	ama	any 2nd 2006		
1	1		29b. Signature and title of certifier DAME OF GOTO 30. Name and address of person who of PRIYA JANANN ATT	ompleted cause of death (I	tem 23a) (Type,	Print)	Rel	+ frager	p GT	Acmo	e lac.	COMMA	Care.	
Y	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig		I PTV(Del	111100	ر ال	The	s ruc	NI/VU	CUIT	
	Registr		18N A G 200		4 Area	Es.								

CPM06-00125 Trisha Lane

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00209 For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Trisha Michelle January 2006 15:36 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 408 Georgia Lane Pasadena Anne Arundel | If Under 1 Year | til Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec. 7,) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2 F 213-23-7154 17 Yrs 1988 Maryland Director Usuat Residence of Decedent the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Exactiner must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 408 Georgia Lane 21122 United States or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "neturei", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ihe F Elementary/Secondary (0-12) College (1-4or 5+) Education Student Pages 1 and 2 should be filed went of Health and Mental Hygie ant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Michael Lane, Jr. April Sadler ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) April Estrada / Mother 408 Georgia Lane Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite eny injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee kîrk Tey-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one days on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finat disease or condition Physician GUNS HOT WOVNO OF HEAD CONTACT resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a surissiquence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): as the burialattending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 5 Other (specify) ate has been signed by the page 2 should be detached 9☐ Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 No 24a. Was an autopsy performed? certificate 2 No or Attending Physician: 25. Was case referred to medical examiner?
1 X yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 I ER/Outpatient 3 DOA Tof Other: 4 Nursing Home 5 Residence & Other (Specify) SCENE this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 13,29 M 1 Natural 5 Pending investigation SUBTECT SYLOT SELF death. 5/06 1 Yes 2 No f Director: / 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify)

RESIDENT 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funerel Direct completely filled in by 4 Homicide 408 GEORGIA LANE, PASADENA, MP Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wood O.C.M.E. January 06, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA PINGIO MD 1111 Penn Street, Baltimore, Maryland 21201 ANA RUBIO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar there it foods JAN 0 9 2006

		For State Registrar	State of	Marylan		artmen rtificate			nd Me		giene Reg. No.	06	00210		
		1. Decedent's Name (First, Middle,	Last)						2	. Date of Dea	ath		3. Time of Death		
Physici /Medic		George Thomas	s Meise							01/03	/200	6 Year	2:15 PM		
Examir		4a. Facility Name (If not institution,	give street and nun	iber)		4b. City,	Town, or L	ocation of D	Death		4c. Cc	ounty of Death			
		Anne Arundel	Medica:	L Cent	er	Ann	apo1	is			Anı	ne Arı	undel		
Funeral				7. Age (In yrs.		If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8 Min.	. Date of Birt (Month, Da 08/06	h v. Year)	9. Birth	place (State or Foreign intry)		
Director		212-36-6856	1 X M 2□F	75	Yrs.				(08/06	/1930	0 0	MD		
and		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits		
Aaryl ed e	ō		Arunde1		asade								1 ☐ Yes 2 No		
28a-	ect	10e. Street and Number	ar under	1	asaue	10f. Zip	Code				100 Citizer	n of What Cou			
with 3e or		7823 Tick Necl	r Pood				122					S.A.	ing;		
ns 2%	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.	.S. 13.1			panic Origin	n? (Specif	fy Yes or No-		Race - Ameri	can Indian.		
r iter	표	1 ☐ Never Married 2 Married	Armed For	^{ces?} 2□No 19	51-	If Yes, spec	ify Cuban,	Mexican, P	Puerto Ric	can, etc.)		Black, White,			
el', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Da	tes: 19	53	1 ☐ Yes 2	No No	Specify:			Sp	ecity: Wh	nite		
72 hc	Completed	15. Decedent's (Specify only highest	Education		16a. Deced			on ring most of	f working		16b. Kind	of Business/In	ndustry		
ithin lear lear	nple.	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. i	DO NOT us	e retired)	mg moot of	, working						
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be fill	Be	17. Father's Name (First, Middle, La	•				1		-	First, Middle,		ŕ			
Mer Mer Marke	은	George Washing		rringe						Rebec					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28a-f ehow empty injury or other traumatic event, Ite Marded Examinar must be notified at once.		19a. Informant's Name/Relationship Phyllis Meise										own, State, Zip			
1 and Healt em 2		20a. Method of Disposition	/ WITE	20b. P	Place of Dispo			CK K	Date	-		ion - City or To	21122		
ages on of t: If it		1 Kanal 2 ☐ Cremation 3		itate C	emetery, cren	natory or of	her place)	73							
urtme urtent ortent njury		 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice 		G L	en Ha			_	-			n Burr			
Department of the post of the		2 Holginature of the latest and the			1747								Home, PA		
		23a. Part1. Enter the dilease, or co	emplications that ca	used the death								na, MI	Approximate		
Physician /Medical Examiner		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death												
	er	Sequentially list conditions, if any, leading to immediate	b. Due to (c	or as a consequ	uence of):							-			
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	0 1	IEEE AND COMMENT						-							
The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)									23d.	23d. Date of delivery Month Day Year			
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w require been sig should b	ete	26 b z (2)							_ [1]			\			
The law cate has page 2:	Completed								-	24a. Was a autops perfor	sy,		psy findings available mpletion of cause of		
sicien: The certificate rector, pag	Be	25. Was case referred to medical examiner?					2	6. Place of	Death (C	Check only or	ne)				
hysi this c	2	1 ☐ Yes 2 No		` .	ER/Outpatien			4 Nursin	ng Home	5 🗌 Reside	ence 6 🗆	Other (Specify	y)		
ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month	Injury , <i>Day Year)</i>	28b. Time of Injury		lc. Injury a Work?		28d	I. Describe h	ow injury oc	curred			
teath tor: / the f	icat	2 Accident investigat 3 Suicide 6 Could not	ho	(1-1 4/1		М		s 2□No							
itel or At irs after o ral Direc led in by	Certification:	4 Homicide determine	od 286. Place of buildin	of Injury - At ho g, etc. (Specify	′)					City or Town	n, State)		il Route Number,		
To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funeral Director: After this certifics completely filled in by the funeral director, I	edical	29a. Certifier (Check only one) 2 Medicel Ex	Physician: To the laminer: On the baann	sis of examinat	wledge, death tion and/or inv	occurred a restigation,	t the time, in my opin	date and pl ion, death o	olace, and occurred	I due to the c at the time, d	ause(s) and ate and pla	d manner as st ce, and due to	tated. the cause(s)		
A Loop Land	Σ	29b. Signature and title of certifier	1	MD		29c.	License n	umber	8=	1 2	9d. Date si	gned (Month,	Day, Year)		
-1	1	30. Name and address of perso	o completed cause	of death (Item	23a) (Type,	Print)	~		VI	1 1	1				
0		Ainée	Yu		f	tun	e P	Irvn	de	, M.	edi	(2)	on ler		
Sta		31. Date filed (Month, Day, Year)		gistrar's Signat	ture	Part.									

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - State Registrar Amend Item	#1 Per P							leg. No	000	00211	
Physic		Decedent's Name (First, Middle, L Lila	ast) McC1	oin	Me	:C1 i	an -		2. Date of Dea Month	th Da		3. Time of Death	
/Medi Exami		4a. Facility Name (If not institution, g				4b. C		ocation of Dea		_	2006 0726 4c. County of Death		
		12 Baltic Ct. 5. Social Security Number 6.	Sex 7.	A (l	to all as to 1	16 1 10	Abero	leen If Under 24 Hr.			Hartfo		
Funeral Director			1□ M 2∏ F	94	. last birthday) Yrs.	Month		Hours Min		Year)	Cou	place (State or Forei	
and *		Usual Residence of Decedent 10a. State 10b. County			ity, Town or Lo	cation			U-2	<i></i>			
Maryli -f eho	tor	Md. Hartfo	ord	1	Aber		l					10d. Inside City Limi 1 ☐ Yes 2 ☐ N	
th the or 28e	Director	10e. Street and Number				10f.	Zip Code			0g. Cit	izen of What Cou	ntry?	
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Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. <u>NaTi</u>	n line.	HA.							Interval Between Onset and Death Y 2 4 / S	
licate be executed physician and s the buriat-transit	edical Examiner												
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w requires that the debeen signed by the should be detached	ρ	Part II. Other significant conditions	contributing to death	but not res	sulting in the un	nderlying	g cause given	in Part I.			ise contribute lo tl ⊇No 3 □ Prot	he cause of death?	
The ate h page	Completed								24a. Was a autops perform	y ned?/	24b. Were auto prior to co death? 1 \sum Yes	psy findings availab mpletion of cause of 2 No	
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To the within 3	Me	29b. Signature and title of certifier	,			2	9c. License n	umber	25	d. Date	e signed (Month,	Day, Year)	
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V		29b. Signature and title of certifier Carolyn C, 7 30. Name and address of person who Carolyn C. Houk, 31. Date filed (Month, Day, Year)	completed cause o	hns IT	n 23a) (Type, I	Print)	eivers.	do 13: Belca	mp. MD	ide 2	Parkwo	y, Suite A	
Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Pog is	strar's Signa	ature	Seek!	1				,		

State of Maryland / Department of Health and Mental Hygiene 📋 🗍 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Calvin 7 2006 Murray 1 10:p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2401 Guilford Avenue Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**∑**M 2□F Yrs. Director 239-05-4993 88 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examinar must be mulfied at 1 Yes 2 □ No Baltimore Md. NA Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2401 Guilford Avenue 21218 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Shipyard 8th grade

17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fit ment of Health and Mental H tent: If item 27 is marked ott jury or other traumatic even Murray Littlejohn Horace Ira 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alethea Ward granddaughter 2401 Guilford Avenue, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Importent: If any injury or once. 1-7-06 Dundalk, Md. Trinity Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 la Warn March F.H. East 1101 E. North Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GRAM SEPTICEMIA NEGATIVE /Medical Due to (or as a consequence of): Examiner INFECTED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the attending physician and thed for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 12 No 1 🗌 Yes 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: Atter this certifice 25. Was case referred to medical Be 26. Place of Death Check only one examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D16619 misone January 4, 2006 cun 30. Name and "ddress of person who completed cause of death (Item 23a) (Type, Print) SQUART-BAGI MORE, MO DR. C. VERGARA - SOARES 9940 FRANKLIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registramend Item #10e&20c Per Fh C856 rtificate of Grath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day McLean Month **Physician** Margaret lanuar 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore (
If Under 1 Year | If Under 24 Hrs. pKins 7. Age (In yrs. last birthday) Ho Johns Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1 M 2 7 F 103-34-155 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehov ?7 is marked other than "natural", or iteme 23a or 28a-f eho: treumatic event, <u>the Madical Examinar must be notified at</u> Director 1 X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2008 Terrance Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 250 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: Block Completed by 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Ben ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb or Rural Route Number, City or Town, State, Zip Code) 2008 Mf. Koya 20b. Place of Disposition (Name of pametery, crematory of other place) Department of Health a Important: If item 27 is any injury or other tree once. 21217 20a. Method of Disposition 20c. Location - Cly or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bronx, NY. emetery 4 ☐ Donation 5 ☐ Other (Specify) 11-2006 22. Name and Address of Facility 21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acute renal failure Physician disease or condition resulting in death) weeks /Medical Due to (or as a consequence of): Examiner dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). The law requires that the death certificate be executed attending physicien and for use as the burial-translt Exam cerebrovascular accident that initiated events resulting in death) Last Due to (or as a consequence of): ivision of Vital Records, P.O. Box 68760, Physician/Medical years IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the infector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus Diabetes 2 No 3 Probably 1 ☐ Yes 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 2 10 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ţ 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funarai Director: All completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 63 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amy E. Spooner, M.D. Johns Hopkins Hospital, Carnegie 568, 600 N. Wolfe Street, Baltimore, MD 2128 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 9 2006 Margar .

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State	of Maryla			nt of He		nd M		giene Reg. No.	006	00214		
	Physici	e ian	Decedent's Name (First, Middle	, Last)						:	2. Date of Dea Month	ath Day	Year	3. Time of Death		
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	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs	. last birthday)	If Unde Months	r 1 Year Days	If Under 2	4 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birthp Cour	place (State or Foreign		
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Hosp	within 24 nous arter doast. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical 5	Physician: To the Examiner: On the band man	e best of my kn asis of examin iner stated.	owledge, death ation and/or in	occurred vestigation	at the time , in my opir	, date and nion, death	place, ar occurred	nd due to the c d at the time, d	ause(s) ar late and p	nd manner as st lace, and due to	ated. the cause(s)		
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	1		30. Name and address of person v	vho completed cau	se of death (Ite		Print)	12.5=	2				TOMO			
180 80	l Sta	ato.	31. Date filed (Month, Day, Year)	1 A-00()	gistrar's Sign	SINA	1 /	TUSF	1177	2	OF	BAR	TOMO	RE		
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** January 0 410 AM 5 06 /Medical 4a. Fecility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Itimore cal Lenter If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Yeel 924 Fadden 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 154M 2□ F 250-30-409 Yrs. Director 0 Usual Residence of Decedent the Maryland 604 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28e-1 show other treumetic event, the Mcdical Examinar must be notified at BATTIMOR 1 Ves 2 No Director MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 212 626 U5 A Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 D-Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 | Yes 2 | 10 Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NQT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Importent: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Cleaner Owner lailor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be J.ess Mic to aden Sarah Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BACTIMORE JOHNNY O. Mc Fodden SON 713 Bloom Way Md. 21201 Cherry 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State injury or • 4 ☐ Donation 5 ☐ Other (Specify) ForesT COUNTISON January 10,206 Our was Wills, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home Street BATTimore, and 21217 N. Gilmor 23a. Part1. Enter the efsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final Physician days disease or condition resulting in death) /Medical Due to (of as a consequence of) Examiner Urihary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) as the burial-transit Cancer oa stric Due to (or as a consequence of): attending physicien for use as the burial of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? neumonic 1 Yes 2 No 3 Probably 4 ¶Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 XNo 24a Was an 21510 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ★npatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C Fo the Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Au4176435F15100 'ash January 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GreNE ST. Baltimore, mozbol 10 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 0 9 2006 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 10f. 19b. 20b per fh 9851 1-24-06 vt. State of Maryland 7 Department of Health and Mental Hygiene For State Registracmend #78*817 Per FH G85 Certificate of Death Reg. No. Item 2. Date of Death JANUARY 04 2006 CATHERINE OSTOVITZ **Physician** MARGARET 4:27 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL COUNTY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan. 27 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 □ M 2 □ F Director 212-22-6477 74 - 78 Yrs Usual Residence of Decedent 31. with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Executor must be notified at 10d. Inside City Limits 1 ☐ Yes 2 📉 No Director Md. Anne Arundel Co. Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21409 1061 Lake Claire Drive -21401U.S.A. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked other than "natural", or Iter Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: white 3 ¼ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Line Supervisor Stalford Aerosol Co. 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Leroy Nash Catherine Margaret Schafer ဂ္ Henry ^{19a} Informant's Name/Relationship *(Type, Print)* Barbara Bennett (Daughter) 19b. 1061 Address (Street and Number or Rural Route Number, City or Town Italiate, Z21409 1016 Lake Claire Drive, Annapolis, 18. 21401 os 1 and 2 sof Health an item 27 ls 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of Hi
Importent: If iter
any injury or oth 20c. Location - City or Town, State 10 to 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 01/09/2006 Baltimore, Md. e of Funeral Service Licensee ^{22.} Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
237 E. Patapsco Ave. Baltimore, Md. J. Wayne Osterling 20a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): be executed as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent oregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 🖼 No 3 Ectopic pregnancy 4□Pregnant at time of death Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. be detached 9 Uлкпоwn 9 🗆 Uлклоwn Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 1 🗌 Yes 1 Yes 2 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation М Director; 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours af Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) within 2 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 06 who completed cause of death (Item 23a) (Twe, Print) 30. Name and 0 ddress of perso 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006 DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1, perMF 0851 1/23/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician James Thomas Patillo JANUARY 2006 10:30A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL 7673 TURNBROOK DRIVE GLEN BURNIE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 3/0 5/1950 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Yrs 55 253-86-1385 Director Usual Residence of Decedent 1 and 2 should be filled within 72 hours after deeth with the Maryland Heatth and Mental Hygiene. em 27 is marked other then "naturel", or Itame 23s or 28s-f ehow 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "naturel", or Itame 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 U.S.A. 7673 Turnbrook Drive Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 (⊈Yes 2 □ No 1968 —
If Yes, Give
Year or Dates: 1973 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Technician **Environmental** traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Betty Jeanne Walker Carter Patillo, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 0 6 0 19a. Informant's Name/Relationship (Type, Print) If item 27 ! 7673 Turnbrook Drive, Glen Burnie, MD Lola Marlene Patillo/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1

Burial 2 □ Cremation 3 □ Removal from State injury or permit. Page Depertment of Important: If any injury or once. 01/12/06 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Veteran Cem 21. Signature of uneral Service Licensee 22. Name and Address of Facility G. J. Gonce Funeral Home, PA 169 Riviera Drive, Pasadena, MD la 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a MYDERTENSIVE MAGROCUERITH CARDINVASCULAM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): $\mathcal{J}(\mathcal{U}_{\mathcal{K}},\mathcal{L}_{\mathcal{K}})$. The physion of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached the t 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 3 Probably 4 Unknown 2 **X1**10 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ es 2 ☐ No has Yes certificete 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) SCENE Hospital: 1 ☐ Inpatient 1 X Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Hospital or Attending t Natural 2 Accident 5 Pending investigation 1 TYes 2 No death. Director: , 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide after To the Hospital's within 24 hours at To the Funerei D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number O.C.M.E. JANUARY 8, 2006 cause of death (Item 23a) (Type, Print) 30. Name and addis 111 PENN STREET BALTIMORE MARYLAND 21201 31. Date filed (Month, Day, Year) 32

DHMH 17 Rev 1/2001

State Registrar

JAN 0

Patient known as James M Palmer III

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Matthews Palmer $\Pi\Pi$ lames January 2:30 PM 5 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner City Baltimore Sinai Baltimore Hospital of If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign
Country) 1 €M 2 □ F 33 214-88-12*5*2 Director MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at **Funeral Director** 1 TYPS 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Northway Aptzoz

12. Was Decedent Ever in U.S. 13. Was Armed Forces? 2406 (454 21215 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 Yes 2 No Specify: Black Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Schnuder Latering 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event ODEs. Be 18. Mother's Name (First, Middle, Maiden Sumame) James M. Palmer, JR Gwendolyn Powel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ballo. Drive Gwendolyn Smith 3102 Elba Mother MI) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Var K 1-13-06 By Ho. MD

22. Name and Address of Facility 8728 Liberty Rd Randallstown MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Funz-d Sevices 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Status epilepticus 15 days /Medical Due to (or as a consequence of): Examiner 3mmunodeficiency Syndrome b. Acquired 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Anpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury investigation М 1 □ Yes 2 □ No 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and till of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 5,2006 Medical Dactor January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Baltimore MD-21215 Vishnu priya, MD 2401 West Belvedere

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

9 2006

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Them 18 per 1h 2851 1-9-06 vt. State of Maryland / Department of Health and Mental Hygiene 00220 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 31308 M SOLOMON ROTH 2006 lan 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death LEVINDALE HEBREW HOME BALTIMORE N/A Birthplace (State or Foreign Country)
 POLAND 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 01/16/1920 1 M 2 □ F Director 175-26-3878 85 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director FL 1 ¥Yes 2 ☐ No **BROWARD** COCONUT CREEK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2101 LUCAYA BEND - APT. B-4 33066 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ğ 1 ☐ Yes 2 X No Specify WHITE 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiene Important: If Itam 27 is marked other the any julyry or other traumatic event, the angles. 8 BUSINESSMAN RETAIL FURNITURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOWN Be YANKTI ROTH **BLUMA** 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5010 HIGHPOINT ROAD - ATLANTA, GA 30342 JAY ROTH / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State DALTON JEWISH CEM. ^ 4 □ Donation 5 □ Other (Specify) 01/05/2006 DALTON, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Se **Physician** RSU /Medical Due to (or as a consequence of): Examiner Mentropenia Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only of e) examiner? apital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year) 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

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Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be notified at

State Registrar

DHMH 17 Rev 1/2001

Ghrzin 31. Date filed (Month, Day, Year,

29b. Signature and title of certifier

30. Name and address of person who

levindale 32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

29c. License number

D0060170

29d. Date signed (Month, Day, Year)

2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7 06 12:26 PM -i 5e Kees /Medical Name (If not institution, give street and Town, or Location of Death County of Death Examiner TOSP 8. Date of Birth Month Day, 9. Birthplace Country) (State or Foreign Social Security Number Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-1 show other treumatic event, the Madical Examinar must be rediffed at 1 ☐ Yes 2 No Funerai Director nore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 Married 1 Never Married Baltimore, Maryland 21215-0036 1□Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Kind of Business/Industry a most of working OW Elementary/Secondary (0-12) llege (1-4or 5+) vrs Department of Health and Mental Information of Health and Mental Important: If item 27 is any injury or other any or other any or other any or other any or other and other any or other any or other any or other any or other any or other any or other any or other any or other any or oth other's Name (First, Mid Father's Name (First, Mid@e, Last) Be 19a Informant 19b. Mailing Ad ress (Street and Number Rural Boute Number, State, Zip Code Name/Relationship (Print) Place of Disposition (Name of Date Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faheral Service Ligen iee 23a. Part 1. Erier the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. listown, MD 21133 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition **Physician** 14-5 42015 tenioscientic /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transil and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐Ectopic pregnancy detached for in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 3 Probably 4 Munknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Yes Hospital: Other: 2 No 2. ER/Outpatient 3 DOA Medicai Certification: To 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Injun 1 🗌 Yes 2 🗆 No death. 2 Accident investigation hours after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) To January 6, 2006 metalle MD 1)18667

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

6 Trimble Hill CT. Lutheru, lle, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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MD

32. Registrar's Signature

			1 - For State Registrar	State of Ma	aryland / De		f Health and North Death	Mental Hyg	ege 06	00222
	Physici		Decedent's Name (First, Middle, La	st)		Smith		2. Date of Deatl Month	Day Year	3. Time of Death 7:55a M
	/Medio Examir	al	Richard 4a. Facility Name (If not institution, giv Joseph Richy			4b. City, Tow	n, or Location of Death Baltimore	<u> </u>	4 2006 4c. County of Deat NA	
	Funeral Director		5. Social Security Number 231–38–4677 Usual Residence of Decedent	Gex 7. Ag	e (In yrs. last birtho 71 Yr	Months Da	ear If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8-1-3		hplace (State or Foreign buntry) N.C.
	Maryland a-f show	ctor	10a. State 10b. County Md •	NA	10c. City, Town o	r Location ltimore				10d. Inside City Limits 1 X Yes 2 □ No
	with the	Director	10e. Street and Number 2842 E. Federal	Street		10f. Zip Cod	21213	10	g. Citizen of What Co USA	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Maraical Examinar must be maillied at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Xipivorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify (of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit	
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7 2	be filed wil ital Hygien of other th	Соп	10th grade 17. Father's Name (First, Middle, Last,			Steel Wor		ne (First, Middle, M	Bethlehem	Steel
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I O M	d 2 sho th and th and 77 is me traume		19a. Informant's Name/Relationship (Vanessa Smith	Type, Print) Daugh			eet and Number or Rui old Ct., Ow			Zip Code) 21117
الم الم	ies 1 and of Health if Item 27		20a. Method of Disposition			isposition (Name or crematory or other	f place)	Date 2	0c. Location - City or	Town, State
. Him	nit. Pag artment ortent: Injury o		Burial 2 Cremation 3 4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer		King	Mem. Pk.	1	0-06	Randallst more, Md.	own, Md. 21202
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	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or common shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to (or as	a consequence of)	rain N	dying, such as cardiac			Approximate Interval Between Onset and Death
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A S	rires that signed b	5	Part II. Other significant conditions of	contributing to death b	ut not resulting in th	ne underlying cause	given in Part I.		acco use contribute to	
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RICHARD Division of	or Attending Physician: The later death. Orlector: After this certificate ha in by the funeral director, page	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ry 28b. Tim y Ye <i>ar)</i> Inju	iry \	njury at Work? 1 □ Yes 2 □ No	28d. Describe how		110-9
1CH Divis	tal or Attences safter death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At home, farm c. <i>(Specify)</i>	, street, factory, offi	ice	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
K	To the Hospital or A within 24 hours after To the Funerel Direccompletely filled in by	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysicien: To the best miner: On the basis of and manner sta	examination and/o	leath occurred at the prince investigation, in m	e time, date and place, ny opinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within To the Comp	M	29b. Signature and tine of certifier). Stel	MO	29c. Lic	ense number		d. Date signed (Monti	
	100		30. Name and address of person who	completed cause of d		rpe, Print) T3C # M	D SONE	OS ItopLi	1 4/01 NS 1+05,	pital
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			For State Registrar	State of	Marylan	•	artment of H		Mental Hygi	ene 0	06	00223
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3	/Medic Examin		4a. Facility Name (If not institution	•	•		4b. City, Town, or	Location of Death		4c. County		
			2800 block of				Baltin			N/		
	Funeral Director		5. Social Security Number 215–86–7103	6. Sex 1⊠M 2□F	7. Age (In yrs. 42	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 4,	^{Year)} 1963	9. Birthpl Count Mary	
3	aryland ehow	20	Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo					10	Od. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f	ecto	Maryland N/A 10e. Street and Number		Bal	timore	10f. Zip Code		10	g. Citizen of \	Mhat Coun	
	th with t	al Dir	2822 Washington	B1vd			21230			USA	What Cour	шу:
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Balt	permit. Page Department Importent: if any Injury or soce.		21. Signature of Funeral Service	Lic-Tisee		1			oudon Par , Baltimo			
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1	/Medical Examiner		resulting in death)	Due to (or as a conseq	quence of):						
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	7		> Cara	e Hall	ano	ud	C	C.M.E.	Ja	nuary	02, 2	.006
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	Funeral Director		5. Social Security Number 6. S	ENERUL A lex 7. Age	(In yrs. last birthday	If Under 1 Year Months Days		Hrs. 8. Date of Bir (Month, Date of Bir 6–10	th 9. Bi	rthplace (State or Foreign country) S.C.
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	the Ma 28a-1 s	ecto	Md. N	IA	В	altimore			10g. Citizen of What C	Yes 2 No
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036	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or liems 23s or 28s-f show event, the Medical Exercites must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of If Yes, specify Cub		? (Specify Yes or No uerto Rican, etc.)	14. Race - Am Black, Whi Specify:	
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Maryland	2 sh and Is m		19a. Informant's Name/Relationship (Demetria Dyer	_{Турө, Print)} Daugh		ing Address <i>(Stree</i> : 8 E. Lorr	tand Number of iane Av	r Rural Route Numbe e., Balti	er, City or Town, State, more, Md.	Zip Code) 21218
altimore,	Pages 1 and 2 nent of Health int: If item 27 iry or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special			osition (Name of ematory or other pla	_ ' _	Date -9-06	20c. Location - City of	
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	Physician /Medical physician and physician and physician and physician sit physician s	cai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence of): a consequence of):	of the	,	er_		Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	y		23d. Date of de Month	alivery Day Year
ecords, P	quires that n signed b ald be deta	by	Part II. Other significant conditions	contributing to death bu	ut not resulting in the	underlying cause gi	ven in Part I.		obacco use contribute t Yes 2 □ No 3 □ P	to the cause of death? Probably 4 Donknown
II Reco	The law require sate has been si page 2 should b	Completed						24a. Was autor perfo 1 Yes	an 24b. Were a prior to death? 2 1 No 1 Yes	
Vital	Phyalcian: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 □ No	Hospital:	nt 2 PER/Outpatie	ent 3 DOA Ot	hon	Death (Check only o	one) dence 6 □Other (Spe	acifu)
Division of	ding h. Afte fune	Certification: To	27. Manner of Death 1 2 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	v 28b. Time	of 28c. Inju		28d. Describe I	how injury occurred	
DİVİ	al or Ati	Sertifi	3 Suicide 6 Could not be determined		iry - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (: City or Tou	Street and Number or R wn, State)	Rural Route Number,
	To the Hospital or Attanwithin 24 hours after deati To the Funerel Director: completely filled in by the	Medical ((Check only 2 Medicel Exer		examination and/or i	nvestigation, in my	opinion, death o		cause(s) and manner a date and place, and du	e to the cause(s)
	ToT	Σ	29b. Signature and title of certifier	1		29c. Licen	se number	36	29d. Date signed (Mon	th, Day, Year)
1) 9		30. Name and address of person who	completed cause of de	eath (Hem 23a) Type	, Print)	rulan	d Gren	neral K	4 Lospital
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 9	32. Registra	ar's Signature	Joseph .				

			1 - For State Registrar	State of M	aryland		irtment of H <i>tificate of l</i>		nd Mental H	ygien Reg. N	.000	00225
6.	Physicia /Medic		1. Decedent's Name (First, Middle, La	J. Ste	wis	77			2. Date of D Month	Death Di	ay ZOO	3. Time of Death
.00	Examin		4a. Facility Name (If not institution, gire	re street and number,	مامه		4b. City, Town, or ANN ap		Death	8	c. County of Deal	cal.
	Funeral Director		5. Social Security Number 6.		ge (In yrs. Ia 53	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of E Min. (Month, I July 2	Birth Day, Year	9. Bird 952 Ma	thplace (State or Foreign ountry)
	death with the Maryland ms 23a or 28e-f ehow Fraint be rediffed at		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Be-f	ctor	Maryland Anne Ar	undel	Glen	Burn	ie					1 ☐ Yes 2 → Ho
	or 28	Olre	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	ountry?
	ath w	ral	7735 Donegal Bay				2106				U.S.A.	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health end Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28e-f ehow other traumatic event, the Medical Exertilise transities notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 Pres 2 If Yes, Give Year or Dates:	No		Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 ☐ No	spanic Origin n, Mexican, F Specify:	n? (Specify Yes or f Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit Specify:	
2-0	natur	eted	15. Decedent's E (Specify only highest gr	ducation		16a. Deced	lent's Usual Occupa	ation	f working	16b. I	Kind of Business	
2121	within lene. then t	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done of OO NOT use retired		, working			
	filed w Hygier Ither th	Col	12	4			Self Empl				Accounta	ant
and	ntal F	Be	17. Father's Name (First, Middle, Las			a .		_	Name (First, Midd			
Maryland	d Ment d Ment marked matic	ဥ	Norman 19a. Informant's Name/Relationship	G.		Steve			othy or Rural Route Num	Н.		ibson
Ma	id 2 sho Ith end 17 is m traum		Phyllis M. Steve							,		yland 21060
5	Health tem 27 other tr		20a. Method of Disposition	ing (wile)	20b. Pla		sition (Name of natory or other place		Date	_	Location - City or	
Baltimore,	uit. Pages artment of ortent: If it injury or of		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		·		en Mem. P		/11/06	G1e	n Burni	e, Maryland
alti	permit. Page Department o Importent: If any njury or once.		21. Signature of Funeral Service Lice	nsee					Funeral	Ноте	D A	o, naryrana
-	80 E = 9		John T.	bellin		3.	204 Mount	ain_ko	ad Pasade	ena,	Maryland	H 21122
A	Physician /Medical		23a. Pan Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Cord	d the death. line.	arrl	er the mode of dying	g, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. End Due to (or as	Skur s a conseque	ence of):	al dis	ase			1	
V '09	tificate be executed ig physicien and as the burial-transit	edicai Examiner	that initiated events resulting in death) Last	C. Due to (or as	s a conseque	ence of):						
68760,	tificate of physical as the b	dice		d								
O. Box (death cer le attendir ad for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal o	death 3□	Ectopic pregnancy Other (specify)				23d. Date of del Month	iv ery Day Year
σ,	s that the ned by a detact	by Pt	Part II. Other significant conditions	contributing to death	but not result	ting in the ur	nderlying cause give	en in Part I.	23e. Dio	tobacco	use contribute to	the cause of death?
rds	w requires that the been signed by th should be detache	ed b	crimosis						10	Yes 2	2 □ No 3 □ Pr	obably 4 Onknown
Records,	law as b	Completed	hepalifis						24a. Wa	is an	24b. Were au	utopsy findings available completion of cause of
<u>=</u>	T ate	Con	malabsoro!	tion					pei 1 ☐ Yes	formed?	death?	
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	U	/				Death (Check only	one)		
of	Phys this al dii	To	1 ☐ Yes 2 No 27. Manne of Death		ient 2 E			4 Nursi	ng Home 5 ☐ Re			cify)
O	ding h. After funei	Certification:	Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year)	28b. Time of Injury	Work	rat ∢? Yes 2⊡No	28d. Describ	e how inji	ury occurred	
Division	Attending r death. sctor: After y the fune	fica	3 Suicide 6 Could not	ne 200 Place of In	njury - At hon	ne, farm, str	eet, factory, office			(Street a	and Number or Ri	ural Route Number,
Ö	s afte	Sert	4 Homicide	building, e	tc. (Specify)				City or 7	own, Sta	te)	
	To the Hospital or Attentwithin 24 hours after deatl To the Funerel Director:	edicai	29a. Certifying P (Check only one) Check only 2 Medical Exa	hysician: To the besi miner: On the basis and manner s	of examination	ledge, death on and/or in	n occurred at the tim vestigation, in my op	ne, date and pointon, death	place, and due to the occurred at the time	e cause(e, date ar	s) and manner as nd place, and due	s stated. to the cause(s)
	To t To t	Σ	29b. Signature and the of certainer				29c. License	number	a —	29d D	ate signed (Mont	h. Day, Year)
			10/1.Ch	~,mi	>	1	D	587	66	1/0	706	
	5		Mi dual Lee	completed cause of	death (Item :	23а) (Туре,	^	1 Me	dical MB 214	Par	Kway	
15 m	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signatu	ıre L	P					
/ -			3/114 0 3	7000	THE PARTY OF	A	500451					

			For State Registrar	State of	f Marylan		artmen			nd M	ental Hyg	iene eg. No.	006	00226
			Decedent's Name (First, Middle, L.	ast)							2. Date of Deat	h		3. Time of Death
	Physici		Michael	Scott	:	Smith					Month Januar	y 2,	2006	6:20AM
1	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and nun	nber)		4b. City	Town, or	Location o	f Death			ounty of Deat	
1	Exami	er	8904 Flower Ave						er Sp				Monts	gomery
					7. Age (In yrs.	last birthday)	If Under		If Under 2		8. Date of Birth			
	Funeral Director			15XM 2□ F	59	Yrs.	Months	Days	Hours	Min.	(Month, Day) Jan • 30	Year)		thplace (State or Foreign
	Director		Usual Residence of Decedent								Jan. 30	, 194	оге	nnsylvania
	and w		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	/ary	ō	Maryland Montgo	m 0.1617			c41,	7076	Sprin	OT.				1 ☐ Yes 2 X _XNo
	the h	Directo	10e. Street and Number	шегу			10f. Zip		SPLIII	5	1	On Citize	n of What Co	nuntry?
	with or		8904 Flower Ave				Tot. Zip	0000	2090	1		-	ted St	·
	8 23	Funerai		12 Was Dags	dent Ever in U	S 10.	Was Danie	I 4 1 1	i- Orio	:-2/0	ait. Van as Na			erican Indian,
	er de	nu	11. Marital Status	Armed Fo	rces?	.3.	If Yes, spec	offy Cubar	n, Mexican	Puerto I	cify Yes or No- Rican, etc.)	14.	Black, White	
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes If Yes, Giv Year or Da	9		1 🗆 Yes 🔞	2 No	Specify:			S	pecify:	White
21215-0036	hour le la la la la la la la la la la la la la	D D	15. Decedent's E		1005.	16a. Dece	dont's Have	I Ossuss	ution.			16h Kind	of Business/	Andustry
5	"nai	Completed	(Specify only highest ga	rade completed)		(Give	kind of wor DO NOT us	rk done d	luring most	of workii	ng	160. Kiriu	OI DUSINGSS/	muustry
2	Mathig Den Den	ם	Elementary/Secondary (0-12)	College (1	-4or 5+)		emp]					17	tertai	
2	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show ent, the Marical Examinar must be molified at		17. Father's Name (First, Middle, Las	. 3		DETI	. –ешр.	Loyer			(First, Middle, I			ımment
~	0 = 0 5	Be	Jack C.	Smi	th					ldre			Smith	
$\frac{3}{5}$	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene and Mental Hygiene is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Mardical Examinar must be notified at	욘				444 44 31		10:						7.0.11
Maryland	permit. Pages 1 and 2 should be Department of Health and Mente Importent: If Item 27 is marked eny Injury or other traumatic et once.		19a. Informant's Name/Relationship Thomas P. Smith		10		•				Route Number			Zip Code)
~	and 2 lealth m 27			/ brotne							ville, N		20781	7. 0
9	of H of H if ita		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 i	Removal from 5	State 200. F	Place of Dispo cemetery, crei	natory or o	ne or ther place	9)				tion - City or	
altimore,	Pages nent of l ent: If its ury or o		4 ☐ Donation 5 ☐ Other (Spec			esapeak	ce Cre	emato	ry	1/4,	/06	Bel	tsvill	e, MD
픎	partr port y Inj		21. Signature of Funeral Servicer Lice	ensee	M0038	Z R2	Name an	d Addres	s of Facility	Cre	emation	Serv	icas	
0	20E 2 8		Steple A John	mann							er Sprin			10
			23a. Part1. Enter the disease, or cor	nplications that ca	aused the deat									Approximate Interval Between
ų.	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	y one cause on e	auri iine.									Onset and Death
)	Physician /Medical		disease or condition resulting in death)		ostate or as a consec		r				-			4 years
	Examiner		- 1	Due to (or as a consec	(derice or).								
М		-a	Sequentially list conditions,	b. Due to	or as a conse	uence of								
J	nsit	uin	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury											
_	xecu and al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):								
760,	ate be executed hysicien and the burial-transit	ical												
84	phys the			_ d.										
9 ×	eath certifica ettending pt for use as t	/Me	IF FEMALE:	23c. If yes, out	come of present	ancy								
Вох	ath o	lan	23b. Was decedent pregnant in the past 12 months?	1☐Live b	irth 2 🗌 Feta	al death 3[Ectopic pr					230	 Date of del Month 	Day Year
<u>.</u>	e de the e	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9∐Unkno	ant at time of c	ieath 5	Other (sp	ecrty)						•
0	The law requires that the death certificate be executed to has been signed by the ettending physicien and age 2 should be detached for use as the burial-transit	Physician/Med				unitalization also and			o So Dool	-	220 Did to			the serves of death?
Ś	res tha igned be de	by	Part II. Other significent conditions	contributing to de	eath but not res	suiting in the u	naeriying c	ause give	n in Part I.					the cause of death?
5	w requir been si should	Completed									1 1	9S 2	NO 3 PI	obably 4 X Unknown
ပ္ထ	law r as be 2 sh	pie									24a. Was a autops		24b. Were au	utopsy findings available completion of cause of
œ	ysician: The is certificete hi director, page	ПО									perform		death? 1 ☐ Yes	_
<u>a</u>	ilcian: Th certificete rector, pag	0	25. Was case referred to medical						26. Place	of Death	(Check only on			
>	ysici s ce direc	0.0	examiner? 1 ☐ Yes 2 [2] No	Hospital:	npatient 2	ER/Outpatier	nt 3□ DC	Othe	or: 4 □ Nu	rsing Hor	ne 5x Reside	ence 6	Other (Spe	cifv)
0	y Phys er this eral di		27. Manner of Death		of Injury h, Day Year)	28b. Time o		8c. Injury Work			28d. Describe ho			//
0	nding I tth. :: After e funer	읥	1 XX atural 5 ☐ Pending 2 ☐ Accident investigate		n, Day rear)	Injury	м		/es 2 □1	No				
Division of Vital Records,	or Attending Physician: after death. Director: Atter this certifice in by the funeral director.	110	3 Suicide 6 Could not determine	286. Place	of Injury - At h	ome, farm, str	reet, factory	, office		2			lumber or Ru	ural Route Number,
á	ē Pigē	Certification:	4 Homicide	Duildi	ng, etc. (<i>Speci</i> i	ry)					City or Town	i, State)		
	Hospital	aic	29a. Certifier 1XXCertifying F	hysician: To the	best of my kno	owledge, deat	h occurred	at the tim	e, date and	d place, a	and due to the ca	ause(s) an	id manner as	s stated.
		edicai	(Check only 2 Medical Exa	miner: On the ba	asis of examina ner stated.	ation and/or in	vestigation	in my op	inion, deat	h occurre	ed at the time, d	ate and pl	ace, and due	to the cause(s)
	To the To the Complet	Me.	29b. Signature and title of certifier				290	. License	number		2	9d. Date s	igned (Monti	h, Day, Year)
	->-0		> helena	PARAN	ing			D35	336			1/3	/06	
			30. Name and address of person			m 23al /Tu=-	Drie*\					, -,		
	' b		- 11		-			Aven	ne v	enei	ngton,	MD ′	20895	
76	Sta	10	31. Date filed (Month, Day, Year)	.202. R	egistrar's Sign		18 1	-14 CII	.uc I		ugeons	2 041	.0033	
	Regist		IAN 0 9 20	Sept.	and fine	and the same	Policy Control							

Donna Jane Tully 06-0134 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylai		artment of H			giene 0 0	6 00227
			Decedent's Name (First, Middle	, Last)					2. Date of De	ath	3. Time of Death
	Physici /Medic		Donna Jane T	ully					Januar		3:50 P M
	Examin		4a. Facility Name (If not institution	•	umber)		4b. City, Town, or		h	4c. County of	Death
			1730 Clarkson				Baltimo			n/a	
	Funeral Director		5. Social Security Number 292-32-3710	6. Sex 1 □ M 2 K F	7. Age (In yrs	last birthday)	If Under 1 Year Months Days	Hours Min	8. Date of Bir (Month, Da 04/03	1h Year) 1938	9. Birthplace (State or Foreign Country) KY
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Manyl f sho	ō	MD n/a				re City				1 X Yes 2 □ No
	1 the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?
	h with		1730 Clarkso	n Stree	+		21230			U.S.A	
	deep	Funeral	11. Marital Status		cedent Ever in t	J.S. 13.	Was Decedent of H	ispanic Origin? (S	Specify Yes or No	- 14. Race -	American Indian,
ð	or it	y Fu	1 Never Married 2 Marr		2 X No		1 □ Yes 2 X No	Specify:	to rucari, etc.,	Specify:	White, etc.
Ş	hours tural	q pe	3 Widowed 4 □ Divorced	Year or	Dates:			****			White
21215-0036	in 72 n "ne de lic	Completed by	15. Deceden (Specify only highes	st grade completed		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wo	rking	16b. Kind of Busi	ness/industry
77	d with piene.	mo.	Elementary/Secondary (0-12) 1 2	College	(1-4or 5+)	Hom	emaker			Own H	ome
9	should be filed within 72 hours efter deeth with the Maryland nd Mental Hygiene. . marked other than "netural", or iteme 23a or 28a-1 show umatic event, it a Medical Exeminar must be redified at	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle	, Maiden Sumame)	
Maryland	Menti Menti mrked	To	Jeoffrey Cli	fton				Shirle	y Benn	er	
la	2 sho	0.1	19a. Informant's Name/Relations		_					er, City or Town, St	
	es 1 and 2 should b of Health and Ment: I item 27 is marked r other treumatic e		Gwen Penningt 20a. Method of Disposition	on/Daug			O Mt. S	avage F	Rd., Fr		, MD 22630
altimore,	permit. Pages Depertment of I Important: If ite any injury or of		1 Burial 2 Cremation		n State	cemetery, crer	natory or other plac	1		20c. Location - C	
	nit. Pa artme ortani injury		4 □Donation 5 □ Other (S	111230 - 0	Bā					Baltim	ore, MD al Home, PA
ä	Den y and y and y		1/2/1								MD 21122
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			BOAL	C CARD	16VAPCI	A/7 A	(RA-6	Onset and Death
	/Medical		resulting in death)	Due to	(or as a conse	quence of):	L CANCID	10077360	וע אאר טו	210121	
I	Examiner		Saquentially list conditions	ь							
	ad Si si	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conse	quence of):					
	and and	Examin	that initiated events resulting in death) Last	c. Due to	o (or as a conse	quence of):					
58760,	cate be executad physician and the burial-transit	dicalE		4							
_		-		u.							
Box	deeth certifi e attending l od for use as	In/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr birth 2 Fet		Ectopic pregnancy			23d. Date	of delivery
	0 0 0	Physician/M	in the past 12 months? 1 Yes 2 No		nant at time of		Other (specify)			Month	n Day Year
0.	at the	Phy	9 Unknowh								
ds,	law requires that the de as been signed by the a 2 should be detached	1 by	Part II. Other significant condition			TURE		en in Parti.	239. 010	1	ute to the cause of death?
Ö	w requ	ete	131 CV COST		, , , , ,	10100			· · · ·		
Æ	vsician: The lav iis certificete has director, page 2	Completed								psy prii prmed? de:	ere autopsy findings available or to completion of cause of ath?
<u>ra</u>	in: T		25. Was case referred to medical					26 Place of Do	1 Yes		Yes 21XNo
<u>=</u>	ysicit is cer direct	To Be	examiner? 1 XYes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatier	t 3 DOA Oth		ath Check only o		(Specify) at scene
0	ding Phys h. After this funeral di		27. Manner of Death 1 □Natural 5 □ Pendin	28a. Date (Mo	e of Injury	28b. Time of	28c. Injun			how injury occurred	
<u>ত</u>	Attending Physician: or death. ector: After this certification is the funeral director.	atic	2 XAccident investi	gation $11/2$	22/05	Unknow		Yes 2 XNo	Fell fr	om stand:	ing
Division of Vital Records,		Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Ptac	ce of tnjury - At I ding, etc. <i>(Spec</i>	home, farm, str lify)	eet, factory, office		City or To	wn, State)	or Rural Route Number,
	Hospital or 24 hours efte Funerel Dir itely filled in		29a. Certifier 1 ☐ Certifvir	a Shusisian Tar	At hom				1730 Clar		Baltimore, MD
	To the Hospital within 24 hours e To the Funere! Completely filled	Medical	(Check only one)	Examiner: On the	ne best of my kr basis of examir inner stated.	iowiedge, deati ation and/or in	vestigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
	ro the round of th	Me	29b. Signature and title of certifie	1	/		29c. Licens	e number		29d. Date signed (Month, Day, Year)
)	X			1 /	1/		0.C.	M.E.		January :	7. 2006
,	2		30. Name and address of person		use of death (Ite		Print)				,
	<u></u>		Mary Kipple,				et, Balti	more, Ma	ryland	21201	
	Sta Registi		31. Date filed (Month, Day, Year)		Registrar's Sign	-6	A9 -				
	negisti	4.11	JAN n 9	2005 8	0.000.00	M. Ao	R.45% 8				

DHMH 17 Rev 1/2001

ORIGINAL

	1	For State Registrar	State of	Marylan		artmer <i>rtificat</i>			and M		giene Reg. No	00	6	002	28
		1. Decedent's Name (First, Middle, Li	ast)							2. Date of De Month	ath Day	,	Year	3. Time	of Death
Physicia Medica/		Avon F. Tyler								01	02		_06	8:30) A M
Examine	_	4a. Facility Name (If not institution, gi	ve street and num	ber)		1		Location o			4c.	County	of Death		
		Washington Adve	ntist Ho	spital		Ta	koma	Park			Mo	ontg	omery	,	
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io E	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Tes :)		1 🗆 Yes	2 X No	Specify:				Specif	v: Bla	ck	
E 444	Da l	15. Decedent's 8		163.	16a Dece	dent's Usu	al Occup	ation			16b K	ind of B	usiness/Inc	dustry	
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rked o	o Be	John Foster						Geor	roia	Foster					
Department of the action wenter hygener important: If Item 27 is marked other than eny injury or other traumatic event, Item 2006.	၉	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ina Addres	s (Street a			l Route Numb	_	or Town.	State. Zip	Code)	
7 Is trau		Beverly Tyler/								nier, M				,	
ther	+	20a. Method of Disposition	2448	20b. F	Place of Dispe	osition /Na	me of			ate			- City or To	wn, State	
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To the Funeral Director: After th completely filled in by the funeral	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	ho -	of Injury - At h	nome, farm, si			195 2 [28f. Location City or To	(Street ar wn, State	nd Numl e)	ber or Rura	Il Route Nu	m <i>ber</i> ,
Funeral Dire	Medical (29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the aminer: On the ba and mann	sis of examina	owledge, dea ation and/or in	th occurred	d at the tin	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time	cause(s , date an) and m d place,	anner as s and due to	tated. the cause	(s)
To the F complete	Ř	29b. Signature and title of certifier	0.					e number			29d. Da	ite signe	ed (Month,	Day, Year)	
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2		30. Name and address of person who			m 23a) (Type	Print)	tin	ST	HyA	. Lbvi	lle n	10	207	82	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 18 per fh 9851 1-10-06 vt.
State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Jan **Physician** 20 Xear Mary Virginia Trapp 5:27 р. м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3543 Tracey's Mill Rd. Manchester Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) | Dec. 22, 122 5. Social Security Number 218–18–0596 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits rat, or iteme 23a or 28e-f show Examiner must be notified at Maryland Carroll 1 ☐ Yes 2 ☐ No Manchester Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3543 Tracey's Mill Rd. 21102 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours efter d Department of Heelith and Mental Hygiene. Important: if from 27 is marked other than "natural", or frem any injury or other traumatic event, the Medical Eventheer ADGE. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Turnbaugh Mary F. Weber -Virginia-2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard A. Trapp - son 213 Presbyterian St. Marion South Carolina, 29571 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory Jan. 7,2006 Baltimore, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chapel P.A. Hall Poleso 6 Charmil Dr. Manchester, Md. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dir com disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner signed by the attending physicien and deedetached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2. No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 20 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Delatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: / completely filled in by the f 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of dentiler 29c. License number 29d. Date signed (Month, Day, Year) 033165 16/6

State Registrar

31. Date filed (Month, Day, Year)

JAN @ 9 2006

Steller Shaffer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pogistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Anyar **Physician** :308 M 2006 Elizabeth Delores Voelker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Arundel Baltimore Washington Medical Center Burnie Glen f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/21/1934 Birthplace (State or Foreign Country) 9. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Months Hours Min 1 M 20% F Yrs. 71 Director 214-30-7305 MD Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Is marked other then "natural", or Items 23a 7644 Brown Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental h Be Ambrose Voqt Clara Leach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other tra Thomas Voelker/Husband 7644 Brown Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem Pk 01/11/06 ¹ 4 □ Donation 5 □ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Var **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of eath Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funerel Director: After t Natural 2 Accident 5 Pending 2 🗌 No investigation 1 Tes 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30: Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar MO KL

31. Date filed (Month, Day, Year)

JAN 0 9 2006

30/ Hospitar 82. Registrar's Signature

		1	State of Maryland / Department of Health State Registrar State of Maryland / Department of Health Certificate of Death			ene () ()	6	00231
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	Physicia /Medic	al -	George E. VASEK.	0		08	06	2:55AM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location 4cod Samaritan Hospital BALTIM			4c. County of	of Death	A
	Funeral	- 3	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	or 24 Hrs. 8. Date	of Birth	Vaari	9. Birtho	ace (State or Foreign
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Baltimore,	0 0		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		20c. Location -		
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.		atory arre	est,		Approximate Interval Between Onset and Death
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Sior	ttandin death. ctor: Aft / the tur	atio	2 Accident investigation M 1 Yes 2					
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Loc Cit	cation (Str y or Town	reet and Numb n, State)	er or Rura	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely tilled in by the	Medical Ce	29a. Certifier (Check only one) 12 Certifying Physician: To the basis of my knowledge, death occurred at the time, date and manner stated.					
	o tha	Mec	29b. Signature and title of certifier 29c. License numbe	er	25	9d. Date signed	(Month.	Dey, Year)
	- s + ō /		Burnetta MD RES 00	0		01/08/	06	
-6	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIJAL M. MEHTA, 5601 LOCH RAVEN BLVD, BF	ALTIMOR				9
	St Regist	ate rar	JAN 0 9 2006					

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		For State Registrar	;	State o	f Maryl	and / De _l	oartmei e <i>rtifica</i>				lental Hy	/gien Reg. N	C 0 (96	002	32
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Funeral		5. Social Security Number 219-28-6001	6. Sex	v 2⊠F	7. Age (In	yrs. last birthda 76 yrs.	y) If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi Month, D DEC 7	inth)	9. Birthp	lace (State	or Foreign
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and		10a. State 10b. County			10c	. City, Town or	Location							1	Od. Inside C	ity Limits
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permit. Pages 1 and 2 should be filed within 72 h Department of Health and Menhal Hygiene. Important: If Item 27 is marked other than "netu any injury or other treumatic event, it a Medical	To Be		nello	0						heri		tewa		,		
should Ind Men	-	19a. Informant's Name/Relations	hip (Type	e, Print)		19b. Ma	iling Addres	s (Street a	and Numbe	er or Rura	al Route Numi	ber, City	or Town,	State, Zip	Code)	
and 2 ealth a m 27 is		Regina Villani	- da	aughte	er	1537	7 Char	lotte	e Ave	nue,	Balti	nore	, MD	212	24	
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		23a. Part 1. Enter the disease, o shock, or heart failure. List	complications	ations that	caused the										Approxima Interval Be	tween
Physician		fmmediate Cause (Final disease or condition				Cio	Carre	1001 -	. of 4	2	THA	1 /1	11 0		Onset and	Death
/Medical		resulting in death)	(a.			sequence of):			8	d	1710	3/1				
Examiner		Sequentially list conditions,	b.	Past	Obstu	etere (meur	rive	X.							
1 D 15	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Į			sequence of	,									
and and	cam	that initiated events resulting in death) Last	С.	COPI		sequence of):										
icate be executed physician and sthe burial-transit		•		D09 10	(Or as a CO	isequerice or).										
physis the	dlcal		d.													
certifi ding se as	Physiclan/Me	IF FEMALE:	23	c. If ves. ou	itcome of pr	egnancy							224 Da	to of dollar		
atten for u	clan	23b. Was decedent pregnant in the past 12 months?		1 Live	birth 2 🗆	Fetal death	BEctopic p							ite of delive onth	Day	Year
the d	ysi	1 □ Yes 2 ☒ No 9 □ Unknown		9□ Unkr			011101 [0	posy/								
The law requires that the death certification is the second of the law requires that the death certification is age 2 should be detached for use as	by Pt	Part II. Other significant conditi	ons cont	ributing to d	ieath but no	t resulting in the	underlying	cause give	en in Part I	l	23e. Did	tobacco	use con	tribute to ti	ne cause of	death?
n sign											1 🚟	Yes	2 🗆 No	3 🗆 Prot	ably 4	Unknown
s bee	Completed										24a. Wa		24b.	Were auto	psy findings	available
The law te has age 2 s	mo										peri	opsy formed?		death?	mpletion of	cause of
vician: Th certificate rector, pag	0	25. Was case referred to medical	ıl						26. Place	e of Deat	1 ☐ Yes h (Check only		10	1 🗆 Yes	21140	
ysici is cen direc	To B	examiner? 1 ☐ Yes 2 € No	Ho	spital:	fnpatient	2 ER/Outpat	ient 3 🗆 D	OA Othe			me 5 Res		6 ROth	ner (Specif	, Reho	eh
fing Phys		27. Manner of Death		28a. Date	of Injury	28b. Time	of	28c. Injury Work			28d. Describe					
ath. Per: Af	atlo	2 3 1 100 100 11	igation	(1010)	,,	.,,	м		Yes 2□	No						
r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr		28e. Plac	e of Injury -	At home, farm,	street, facto	ry, office			28f. Location City or To	(Street a	and Numi	ber or Rura	l Route Nur	nber,
To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page																
Hosp 24 hou Fune Telly fil	edical	29a. Certifier 1 ☑ Certifyi (Check only 2 ☐ Medical	ng Physi Exami <i>n</i> e	er: On the l	pasis of exa	knowledge, de mination and/or	ath occurre investigation	at the time, in my of	ne, date ar pinion, dea	nd place, ath occuri	and due to the red at the time	e cause(e, date a	s) and m nd place,	anner as s	tated. the cause(s)
thin 2 the other	Med	29b. Signature and title of certific	ər	and mar	nner stated.		25	c. License	e number			29d D	ate sinne	ed (Month	Day, Year)	
Z Z Z 8		144.0	A.	At	. m ^				76	2	1		_			1
^		30 Name and address of a	You	we	2 1/11	/Itam 22s) (T		- J-J	14.			year	ua)	uf 1	1000	6
2		Grace A. Cord	+ = in			OPKINS		Vilad	Circ	10	Balti	mer	0 /	na	2122	4
Sta	ate	31. Date filed (Month, Day, Year) V		Registrar's S		, 500	7,000	-112	-14	JAC 17		1	- 20		
Regist		1831 0	0 20	00	No	of out	Burgalle	j								

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Woodley 20:24M Albert January 1, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore ()
If Under 1 Year If Under 24 Hrs. HOPKING HOSPITA JOHUS age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1[**X**M 2□ F Months Days Hours Min Director 227-40-9320 Va. Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State itam 27 la marked othar than "natural", or Items 23s or 28a-1 show other traumatic evant, It we Medical Exercities mast be notified at 1X Yes 2 □ No Md. NA Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1424 N. Milton Ave. 21213 Completed by Funeral USA deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Steelside Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental F Woodley ဂ္ Paul Lula Drumqoole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 Wife Cora Woodley 1424 N. Milton Avenue, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State rtant: If its 1
☐ Burial 2 □ Cremation 3 □ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cem. 1-9-06 Baltimore, Md. permit.
Dep-rtn
Importa
any inju 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. 21202 lady March F.H. East 1101 E. North Ave. Wan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Intracerebral Hemorrhage 24 hours disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Hyper Heasion
Due to (or as a consequence of): 30 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy 2 No 1 ☐ Yes Division of Vital Hospital or Attanding Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hospital within 24 hours a To the Funaral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) RE5-000 January 1,2006 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boltimore 600 N. Wolfe 54 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H			iene () () (00235
	Physicia /Medic		1. Decedent's Name (First, Middle, La:	(ARI)	W00	DS		2. Date of Death Month	Z O'	3. Time of Death p 5.45 M
	Examin		4a. Facility Name (If not institution, give Haven Nursi	//	le	K-11	Location of Death		4c. County of E	Death
	Funeral Director		012-17-41-50	ex. 7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (North, Day)	(ear) 9.	Birthplace (State or Foreign Country)
	Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or La					10d. Inside City Limits 1 XYes 2 □ No
	death with the Maryland ims 23a or 28a-f ehow finant be neithed at	Director	10e. Street and Number 2939	st Aug	De la	10f. Zip Code	215	10	Og. Citizen of What	t Country?
' O	tter death	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent I Armed Forces? 1 Yes 2 1	No.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	Black, V	American Indian, Vhite, etc.
21215-0036	within 72 hours atter ene. than "natural", or Ita	Ď	3 Widowed 4 □ Divorced 15. Decedent's Edition (Specify only highest grade)	Year or Dates:	16a. Dece	1 ☐ Yes 2 No dent's Usual Occup	Specify:	ina 1	Specify:	3.40C/C
2121	ges 1 and 2 should be filed within 72 hours atter death with the Marylan tt ot Health and Mental Hygiene. If itam 27 Is marked other then "natural", or Itams 23a or 28a-f ehow or other traumatic event, Ita Medical Erge in et mast be published.	Completed	Elementary/Secondary (0-12)	Allege (1-4or 5	/ife.	kind of work done of DO NOT ute retired	Worke		Bethlel	nem Steel
Maryland	2 should be filed withir and Mental Hygiene. Is markad othar than aumatic event, Italia	To Be	Rutus Wood	S _	``		18. Mother's Name		naiden Sumame)	
	1 and 2 sho Health and tam 27 is mather traum	(9a. Informant's Name/Relationship (インスト	on 3211	Buning	101101	Guyna	Oak, m	D 21207
Baltimore	Pages 1 ment of Hi ant: If itan ury or oth		20a. Method of Disposition Burial 2 Cremation 3 Donation 5 Other (Specif.	Removal from State	20b. Place of Dispo cemetery, crea	osition (Name &) mator or other place	1-9		Location - City	
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Fundral Service Licer	Greene		2. Veandagles 728 Libe	ss of acilit Gre	ese full	revalo	mb 2/133
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each lin	the death. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arre	LEGS	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as	a consequence of):	ARC	A			
	and Il-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· 1774	ELOD	YSPCA.	1871c -	5414	DROM	Ä
8760,	cate be executed physician and the burial-transit	dicai Ex	resulting in death) Last	Due to (or as	a consequence of):	114				
Box 6	ath certitic attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ls, P.O.	ires that the d signed by the d be detached	by	9 ☐ Unknown Part II. Other significant conditions of		ut not resulting in the u	inderlying cause give	en in Part I.	23e. Did toba		e to the cause of death?
Records,	e law requ has been le 2 shoul	ompieted	BENIGA	Pros	TATIC	HYPER	PLASIA		24b. Were	autopsy findings available to completion of cause of
Vital	Physician: The this certificate har all director, page	BeC	25. Was case referred to medical examiner?	Hospitali		04	26. Place of Death	1□ Yes 2	2 0√0 1□1	res 2□ No
o	Phys this ral dii	ion: To	1 Yes 2500 27. Manner of D ath 1 Shatural 5 Pending	Hospital: 1 Inpatie 28a. Date of Injury (Month, Da)	ry 28b. Time o	l 28c. Injury Work	/ at	me 5 Resider 28d. Describe hov	nce 6 Other (S w injury occurred	Specify)
Division	tand leath tor: the	Certification:	I ☐ Accident investigation I ☐ Suicide I ☐ Could not be determined		ury - At home, farm, str c. (Specify)		Yes 2 □ No	281. Location (Stre City or Town,	eet and Number or State)	r Rural Route Number,
	Hospital 4 hours Funeral ely tilled	edical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best on niner: On the basis of and manner sta	of my knowledge, deat examination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the car ed at the time, da	use(s) and manner te and place, and o	r as stated. due to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	11110	La us	29c License	number 3/GO		d. Date signed (M	onth, Day, Year)
9	5		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type.	Print) Print) ALTIM	ont, A	40/2	2121	· S
	Sta Registr		31. Date liled (Month, Day, Year)	180	ar's Signature	Les .				

			1 - For State Registrar	State of M	larylan	•	artmen rtificate					giene Reg. No.	006	00236
	Physici	20	1. Decedent's Name (First, Middle, Las	,							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medio		Dessie B.	Williams	5						01	03	06	8:00 A M
	Examin		4a. Facility Name (If not institution, give)				Location	of Death			County of Death	
			Sligo Creek Nursi						Park	0411			ontgome	
	Funeral	ĺ	5. Social Security Number 6. S	ex		last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Da 12 16	h y, Year)	Cou	place (State or Foreign intry)
	Director		246-32-4980 Usual Residence of Decedent		78	113.					12 16	21	Nort	h Carolina
	land		10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside City Limits
	Mary I sh	Ď	MD Prince G	orgas	R-	rentwo	od							12√ Yes 2 No
	r 28e	Director	10e. Street and Number	COLECT	15.	LCIILWO	10f. Zip	Code				10g. Citiz	en of What Cou	intry?
	N with	0	3809 39th. Street				2	0722	2				USA	
	deat	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.	S. 13.	Was Deced	lent of Hi	ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	. 1	4. Race - Amer Black, White	
ထ္	after or Ite	图	1 Never Married 2 Married	1 Tyes 2 1			1 ☐ Yes				riloan, ato.)			
8	ours rel',	Completed by Funeral	3 A Widowed 4 □ Divorced	Year or Dates:								`	Specify: Bla	ck
7	net	ete	15. Decedent's Ed (Specify only highest gra	ducation de completed)		(Give	dent's Usua kind of wor DO NOT us	rk done d	during mos	t of worki	ing	16b. Kin	d of Business/li	ndustry
12	withir ane. Ithan	du	Elementary/Secondary (0-12)	College (1-4or	5+)		sewif		,			A :: \	N Hor	20
2	filed within 72 hours after death with the Maryland Hygiene. uther than "neturel", or Items 23a or 28e-f show ent, the Medical Examinat must be mulfied at	ပိ	17. Father's Name (First, Middle, Last)	1		nou	ISEWII	.е	18. Mothe	er's Name	(First, Middle,	Maiden S		VC
an	d be antal ced o	o Be	William Whitesid								Fields		,	
Maryland 21215-0036	shoul nd Me mark	^L	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street a				er, City or	Town, State, Zi	p Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "neturel", or Items 23a or 28e-1 show or other treumatic event, the Medical Examiner must be millied at		Rosa Azuine/Daugh	ter		3809	39th.	Str	eet]	Brent	wood, 1	MD. 2	20722	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tre ance.		20a. Method of Disposition		20b. P	lace of Dispo emetery, crei					ate		ation - City or T	own, State
E	Page ient c int: If		1 ABurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification)		3	mony M			l l	1-9-0)6	Land	lover, N	D.
Ħ	mit. partm porte		21. Signature of Funeral Service Licer		, III								neral Ho	
m	permi Depa Impo any ir	. 9	P May	hall									D.C. 2	
			23a. Partil. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the death									Approximate Interval Between
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	/Medical		resulting in death)	Due to (or a										
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/	ecute and trans	Examiner	that initiated events resulting in death) Last	c. Cerebr			ccide	nt						
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	physic the	dlcal		d. Diabe	tes H	CITICO				-				
9 x	death certific e attending p od for use as	Physician/Me	IF FEMALE:	23c. If yes, outcom	e of pregna	incv						2.	3d. Date of deliv	ren/
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Feta	death 3	Ectopic pr					2.	Month Month	Day Year
o.	0 0	ysl	1 Yes 2 No 9 Unknown	9□ Unknown					·					
٣	The law requires that the site has been signed by the bage 2 should be detache	by PI	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying c	ause give	en in Part I		23e. Did to	obacco us	e contribute to	the cause of death?
rds	quires n sign	d b									101	∕es 2□	No 3∏Pro	bably 4 X Unknown
Vital Record	s been si	Completed									24a. Was		24b. Were aut	opsy findings available
Re	The law ate has page 2 s	шо									autop perfo	rmed?	death?	ompletion of cause of
ta	(0	0	25. Was case referred to medical						26. Place	of Death	(Check only o		10.66	20110
>	Physiclen: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🎛 No	Hospital: 1 ☐ Inpat	ient 2 🗆	ER/Outpatier	nt 3 DO	Othe	or				Other (Speci	fy)
0	ng Ph ter th neral		27. Manner of Death	28a. Date of In	jury av Year)	28b. Time o	f 2	8c. Injury Work	at		28d. Describe I	now injury	occurred	
io	Attending r death. ector: After by the fune	atlc	1 Matural 5 Pending 2 Accident investigation	n i			М	1 🗆 `	Yes 2 🗆	No				
Division of	el or Attending Physis safter death. I Director: After this cad in by the funeral dire	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of it	njury - At ho	ome, farm, str	reet, factory	, office			28f. Location (5 City or Tox	Street and vn, State)	Number or Rui	al Route Number,
	itel o													
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	(Check only 2 Medical Exar	ysician: To the bes niner: On the basis	of examina	wledge, deat tion and/or in	h occurred vestigation,	at the tim , in my op	ne, date an pinion, dea	id place, a th occurr	and due to the o ed at the time,	cause(s) a date and p	and manner as : place, and due :	stated. to the cause(s)
	the the mplet	Med	29b. Signature and title of certifier	and manner s	itated.		290	. License	number			29d Date	signed (Month	Day Year)
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	/		9					, 577	_					
	う		30. Name and address of person who Steven T. Tee,		death (Item Hamil	ton St	. #1	Hyat	tsvi	lle,	MD. 207	782		
	Sta	te		32 Benis	trar's Sigria									
	Registi		31. Date filed (Month, Pay, Year)	16	3 50	Contract of the Contract of th	- Breite.							

		T = For State Registrar	State of I	Maryland /	•	artment tificate			ind M		giene 0 0	6 0	0237
Dhye	sician	Decedent's Name (First, Middle,	Last)			•	1.			Date of Dea Month		3. Year	. Time of Death
	edical		John	T.				Sr.		Januar	y 4, 200		4:15 A M
Exar	miner	4a. Facility Name (If not institution,		er)				Location o Iowar			4c. County of Balti		
	4	9324 Todd Ave		Age (In yrs. last t	hirthday)	If Under		If Under		8. Date of Birth			(State or Foreign
Funer Direct		214-24-1543	1 1 2 M 2 ☐ F	77	Yrs.	Months	Days	Hours	Min.	(Month, Day	r, Year)	Country)	
*	.01	Usual Residence of Decedent	1				1.		h	June 12	,1928	Maryl	Land
yland	rr L	10a. State 10b. County		10c. City, To	own or Lo	cation							Inside City Limits
a-fa	cto	Maryland Ba	ltimore					F	ort I	Howard		1	1 ☐ Yes 2 📆 No
ih th or 28	l e	10e. Street and Number				10f. Zip	Code	2	1050		10g. Citizen of Wh	at Country?	•
ath w	Funeral Director	9324 Todd Aver							1052		United		
er de Itams	E e	11. Marital Status	12. Was Decede Armed Force	es?	13.	Was Deced f Yes, spec	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto f	cify Yes or No- Rican, etc.)	Black,	- American Ir , White, etc.	
36 saft	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes 2 If Yes, Give Year or Date			1 ☐ Yes 2	X No	Specify:			Specify:	Whi	ite
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Wher then "natural", or Itams 23s or 28s-f show mit, fre Mydical Exprinter cust be mullised at	e e				Sa. Dece	dent's Usua	I Occupa	tion			16b. Kind of Busi	iness/Indust	try
21.5 2. iii 2. iii	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4	or 5+)	(Give life.	kind of wor DO NOT us	k done d e retired)	uring mosi	t of workir	ng			
id 212 filed withi Hygiene. other there	l e	8 Years	College (1-4	01 37)	St	eel W	orke	r			Signo	ode	
of Hy	Be		_ast)					18. Mothe	r's Name	(First, Middle,	Maiden Sumame))	
laryland 21215-0036 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural; or items 23a or 28a-f ahow aumatic event, Ita Mulcal Extinition must be notified at	2	Willie Wright						Glad	dys P	angle			
Maryland 2121 of 2 should be filed within tith and Mental Hygiene, 27 is marked other than "		19a. Informant's Name/Relationsh		J		-					r, City or Town, Si		
		Mrs. Terri L.	Biedenbac		1080	4 Hig		ry Wo			Midlothia		
altimore, rrait. Pages 1 ar portant: If Item yindury or othe		20a. Method of Disposition 1 □XBurial 2 □ Cremation	3 Removal from St	20b. Place ceme	tery, crei	natory or o	ne or ther place	9)	D	ate	20c. Location - C	ity or Town,	State
Baltimor permit. Pages Department of t Important: if ite		4 Donation 5 Other (S)		Bel						/2006	Bel Air		yland
Demini mpor	DC.	21. Signature of Funeral Service I	Licensee		Di	2. Name an 1da – Ri	d Addres ICK F	s of Facility uner	al Ho	ome of	Dundalk,	Inc.	
4024		Media a	Sone	and the fieth D							aryland		pproximate
	18	23a Part1. Enter the disease, or shock, or heart failure.	only one cause of Fac	sh line.	o na en	er ine mod	or dyling	J, Such as) Idiac o	i lespiratory ar	rest,	Inte	terval Between
Physicia /Medic	_	Immediate Cause (Final disease or condition resulting in death)	-a/(witte .	100	max	, 1	ay	w	re		2	Months
Examin	_		Due to lo	as a const period	e of):		Иu	o Va	Lmo			7	mother
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequenc	perof):	V 1	1		, , ,			-	// CXI SU
uted uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S .										
D, C exec an an			Due to (or	r as a consequenc	ce of):								
Box 68760, death certificate be executed e attending physician and of or use as the burial-transit	2		d										
68 rtifica ng ph	Physician/Medical	IF FEMALE:				_							
Box 66 leath certifica attending pt	/ue	23b. Was decedent pregnant		ome of pregnancy th 2 Fetal dea	ath 3[∃Ectopic pr	egnancy				23d. Date Mont	of delivery	y Year
O. B. B. B. B. B. B. B. B. B. B. B. B. B.	200	in the past 12 months?	4☐Pregnar	nt at time of death	5[Other (sp	ecify)				Mont	th Day	y ieai
ecords, P.O. I law requires that the de- as been signed by the a	Phy Ph	9 Unknown	NO contribution to don	th hut not requitie	a in the c	a de el de e		n in Dant I		220 Did to	obacco use contrib	/ to the e	auen of doath?
COLDS, Powered that we requires that is been signed to should be detailed.	عًا ا	Part II. Other significant condition	nis contributing to dea	un dui not resulun	g in me u	rideriying c	ause give	n in Part i		1 N	_/	3 Probably	
Vital Records, sicien: The law requires to certificate has been signe	Completed	2/3/2											
Receian elaw	4 6	17100								24a. Was autop perfo	osy pri	ere autopsy for to comple eath?	findings available letion of cause of
Vital Relicion: The contilicate his										1 ☐ Yes		Yes 2	□ No
Of Vital Re Physician: The I rithis certificate ha	8	examiner?	Hospital:				Othe)F:		(Check only	ne)		
Phys rr this	1		28a. Date of (Month)	patient 2 ER/	Outpatie b. Time c		28c. Injury Work	4 🗆 NL	rsing Hor		dence 6 Other		
VISION Attending I releath.		1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investig		, Day Year)	Injury	м		(? Yes 2 🔲					
Division I or Attending after death. Director: Afte	()	3 Suicide 6 Could	fied 289. Place C	of Injury - At home	, farm, st	reet, factor	, office		- :		Street and Number	r or Rural Ro	oute Number,
Div	Certification.	4 Hornicide	bullaing	g, etc. (Specify)						City or Tov	vn, State)		
DIVISION OF To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th companient illad in by the funeral) le		g Physician: To the b Examiner: On the bas	est of my knowled	dge, dea	th occurred	at the tim	ne, date an	nd place, a	and due to the	cause(s) and man	ner as state	id.
the H in 24 in E	pieleny in		and magne	r stated	androrii				un occurn	ed at the time,	date and place, ar	ad due to the	a cause(s)
To the within 2	2	29b. Signature and title of certifie	I K		, 11	290	c. License	number	11	-	29d. Date signed	-/	v, Year)
,		Medric	XI	vua	141	リ	1) (((OY	7	1/5	106	
(Υ)	30. Name and address of person	who completed cause	of death (Item 23	a) (Type	Print)	200	150	10	0 1-	-0/-	A AA	2:201
6 3 5 5	C	31. Date filed (Month, Day, Year)	1)1/1/1	gistrar's Signature	2.	705	US	IK	かべ、	SUITE	306 Tou	SONYMX	5, 21204
Rec	State gistra	INN A Q	2006	to fit	SOM	451							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				State of Maryland / Department of Health and N 1 - State Registrar Certificate of Death		iene g. No.	00238								
		Physici	an	1. Decedent's Name (First, Middle, Last) William E. Button	2. Date of Deat Month	Day Year	3. Time of Death								
		/Medic	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	January	7, 2006 4c. County of Dea	11:50 A M								
		Lxuiiiii		Gilchrist Center Towson		Baltim									
		Funeral Director		5. Social Security Number 217-03-8142 6. Sex 1 Number 1	8. Date of Birth (Month, Day) Feb. 6,	1903 Ma	thplace (State or Foreign ountry) LYLAND								
		show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits								
		Be-f	ecto	Maryland Baltimore Baltimore		log. Citizen of What C	1 ☐ Yes 2 No								
		ter death with the Maryla Items 23a or 28e-f shov	I D	10e. Street and Number 3800 Wean Drive, Apt. 2A 21236		U.S.A	· ·								
		death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Am Black, Whi									
	21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28e-f show ite Medical Exerciant musi be notified a	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify:			White								
	5-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business	s/Industry								
	2121	l withir liene.	ошо	Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Tour Guide		Motor Tou	rs								
	pu	2 should be filed wi i and Mental Hygien is marked other th raumatic event, Illa	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name		Maiden Sumame)									
_	Maryland	should band Ment	2	Elmer Button Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	·		7'- Code l								
4	Mai	0 F L ~		19a. Informant's Name/Relationship (Type, Print) Ms. Claire Button (daughter) 3800 Wean Dr., Apt. 2			21236								
1150 Am	Je,	s 1 and 2 of Health itam 27 i		20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City o	r Town, State								
1	imo	Page ment cant: If		4 Donation 5 Dother (Specify) Most Holy Redeemer 1/1		Baltimore,									
و	Baltimore	permit. Pages 1 and Department of Heali important: If itam 2 any Injury or other once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sch Burin G Willer 23. Name and Address of Facility Sch 7705 Belait Ru., I											
0		er		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory are	rest,	Approximate Interval Between Onset and Death								
		Physician /Medical		tomediate Cause (Final disease or condition a. Congestive heart failure YEG)											
_		/Medical Examiner		Due to (or as a consequence of):											
5			ner	Sequentially list conditions, if any, leading to immodiate cause. Enter Undertying Cause (Disease or injury											
31	1/20	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):											
	68760,	icate be executed physicien and s the burial-transit	edical E	d.											
3	89	intificating physes as the		IF FEMALE:			I								
then?	D. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Un		23d. Date of d Month	elivery Day Year								
+,	, P.O.	s that the de ined by the e e detached f	y Ph	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute	to the cause of death?								
8	ords	w requires that been signed t should be deta			1 🗆 Y	′es 2 No 3 I	Probably 4 Unknown								
	Division of Vital Records,	Physician: The law r this certificete hes be al director, page 2 sh	Completed			rmed? death?	autopsy findings available completion of cause of								
	/ita	ician: Sertific ector,	Be	examiner? Hospital: Other	th (Check only o		1/								
	of	Physic ruthis creal direction	To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		lence 6 Other (Sp now injury occurred	recity) Itospice								
	ion	nding F ath. r: After e funer	atior	1 █≸slatural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No											
	ivis	or Attendiffer death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (5 City or Tox	Street and Number or vn, State)	Rural Route Number,								
		Hospital 4 hours a Funeral C	edical Ce	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur											
		To the Hos within 24 h To the Fun completely	Med	one) and manner stated. 29b. Signature and title of certifier 22c. License number		29d. Date signed (Mo	nth, Day, Year)								
		F ≯ F 8		Jaron Sand 00061199		Jan. 7.	2006								
		di		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason Black 660 I Worth Charles ST, Tows	-an, 1	40 212	204								
		Sta Registr		Jason Black 660 I Worth Charles ST, Tows 31. Date filed (Month, Day, Year) JAN 1 0 2006 32. Régistrar's Signature											

				and / Department of Health and Mer	ital Hygiene nns nn239
			State Registrar Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No.
	Physici /Medic		ROBERT E.	Balla	Date of Death Month Day Year Onuary 5, 2006 905 P M
)	Examin	er	4a. Facility Name (If not institution, give street and number) May Uland General Hos	pital Ratimore Cy	4c. County of Death
秦	Funeral Director		5. Social Security Number 6. Sex 7. Age (In)	rs. last birthday) Tr Under 1 Year It Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth Month, Day, Year) A.N. 01, 1941 WASH. D.C.
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c	City, Town or Location	10d. Inside City Limits
	e Mary	Director	MARYLAND NIA	BALTIHORE	
	3e or 2	i Dire	10e. Street and Number	101. Zip Code 21217	10g/Citizen of What Country?
	r death	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	n U.S. 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- 14. Race - American Indian, n, etc.) 18lack, White, etc.
920	4 within 72 hours after death with the Maryland jiene. I then "natural", or iteme 23e or 28e-f show The Medical Epartinat must be mullied at	þ	1 Never Married 2 Married 1 Yes, 2 Married 1 Yes, Give 1f Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: 131 ACV
21215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry
2121	filed within Hygiene. other then "	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired) LABORER	BALTO. CITY PUBLIC WORKS
	d a b	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fi	rst, Middle, Maiden Surname)
Maryland	2 should be and Mental is marked of sumetic eve	ဥ	19a. Informant's Name/Relationship (Type, Print)	3ROOKS CAREY 19b. Mailing Address (Street and Number or Rural Address)	oute Number, City or Town, State, Zip Code)
	s 1 and 2 should Health and Mer Item 27 is marke other traumatic		FLORENCE JENKINS (SISTER	2 4 S. ROSEDALES	ST., BALTO. MD. 21229
Baltimore	000==		1, Surial 2 □ Cremation 3 □ Removal from State	b. Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State
altin	그 든 뿐 분	- 0	4 Donation 5 Other (Specify) 21. Signature of Fungral Service Licensee		WN JR. FUNERAL HOME
ä	Depermine the perm		Vertich N. Will	amo 2140 N. FULTON A	VE, BALTO, MD. 21217
	Physician		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final	death. Do not enter the mode of dying, such as cardiac or re	spirator√ arrest, Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a cor	sequence of):	() (/
	Examiner	ē		e Kenal Anslase on sequence of):	Hemodialysis
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	ision	
8760,	ate be executed hysicien end the burial-transit	cal Ex	resulting in death) Last Que to (or as a con	sequence of);	
9	tificate og phys as the		d		
Box	The law requires that the death certificate be executed ate has been signed by the attending physicien end bage 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of proposition in the past 12 months? 4 □ Pregnant at time	Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
P.O	that the de ed by the deteched		9 ☐ Unknown Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
rds,	w requires that been signed should be del	ed by			1 Yes 2 No 3 Probably 4 Dunknown
Records,	e jaw re has bed je 2 sho	Completed			24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
	sician: The certificate he rector, page	0	25. Was case referred to medical	26. Place of Death (C	1 Yes 2 No 1 Yes 2 No
of Vital	Physician: this certificatal director, p	To B		2 ER/Outpatient 3 DOA Cther: 4 Nursing Home	5 Residence 6 Other (Specify)
ion	After fune	ation	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Yea	28b. Time of 28c. Injury at 28d. 28	Describe how injury occurred
Division	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Certification:	S C Could not be	At home, farm, street, factory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or within 24 hours effer To the Funeral Dircompletely filled in I	edical (29a Certifier (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, death occurred at the time, date and place, and mination and/or investigation, in my opinion, death occurred a	disc to the cause(s) and marker as stated it the time, date and place, and due to the cause(s)
	Vithi Vithi Comp	W	29b. Signature and title of certifier	29c. License number 8 9 5 3 5	29d. Date signed (Month, Day, Year)
6)		30. Name and address therson who completed cause of death		al Hospital
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 0 2005 32. Registrar's S	signature Section 1	

			For State Registrar	State of Maryland		nt of Health and te of Death	Mental Hygien	4000	00240
	Physici	an	Decedent's Name (First, Middle, La.	st)	0		2. Date of Death Month D	ay Year	3. Time of Death
	/Medic	_	Lewis			own	January S	-14 2006	7:14 PM
	Examin	er	4a. Facility Name (If not institution, give			, Town, or Location of Deal	4.0	c. County of Death	
	Funeval		5. Social Security Number 6. S	Maryland Med	ast birthday) If Und	er 1 Year If Under 24 Hrs	8. Date of Birth ,	9. Birthc	lace (State or Foreign
4,	Funeral Director			ADM 2□F C	Yrs. Month:	Days Hours Min.	(Month, Day, Yea)	1 Speri	itry) III VIA
	ow itand		10a. State 10b. County	10c. City	, Town or Location			1	0d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f ehow other treumatic event, the Madical Executer must be notified at	ctor	MD			timore			1 Yes 2 □ No
	h with th	Funeral Director	10e. Street and Number 3323 Elw	ley Avenue	10f. 2	ip Code 21213	10g. C	Citizen of What Coun	ntry?
	deed deed	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
36	or it		1 Never Married 2 Married	1 MYes 2 □ No If Yes, Give	1 ☐ Yes	4	,	Specify:	· [.
5-0036	hours tural;	ed by	3 Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16a. Decedent's Us		16h	Kind of Business/Inc	146.
215	in 72 n "na Madic	plete	(Specify only highest gra	ade completed)	(Give kind of v	ronk done during most of wo	rking	King of business/inc	dustry
212	filed within Hygiene. Ither there with the Merities with the Merit	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	rainte		Ce	ontracti	$i \circ a$
and	be filed stal Hygind other event, I	Bec	17. Father's Name (First, Middle, Last,		`	18. Mother's Na	me (First, Middle, Maide	on Sumame)	
yla	should be ind Mental I	ပို	huther l	n. Brown		1161	lie Wood	ard	
Maryl	12 sho h and 7 is mu ireum		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addre	ss (Street and Number or R	12 11.	4.0	Code)
	1 and Health em 27		20a. Method of Disposition	20b. PI	lace of Disposition (N	ame of		Location - City or To	wn, State
JOI.	ages ant of it: If it y or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Hemoval from State	emetery, crematory of	other place)	. 0	ultimore	
Baltimore,	permit. Pages 1 and Department of Health Important: if Item 27 any injury or other tr once.		21. Signature of Funeral Service Licet	1.90	22. Name	and Address of Facility	tymore,		
ä	Depa Impo any ir		Kimbroly C	2 Solly	EVAN.	FUNERAL	CHAPFL 8	900 HARF	ontopp.
Н			23a. Part1. Enter the disease or com shock, or heart failure. List only	plications hat/caus id the death one cause on each ine.	. Do not enter the m	ode of dying, such as cardia		SSOUTH PROBABLY PIN	Approximate Interval Between
111	Physician		Immediate Cause (Final disease or condition	1 schemi		ke			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ					
4g *	J. Me a).	Sequentially list conditions,	b. Intapar Due to (or as a consequ	enchy mas	bleed			
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	hupertal	() a al				
Ć.	execuin and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):				
8760	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cai		d					
9	death certifica attending ph	Physician/Medical	IF FEMALE:						
Box	ath ce attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 □Ectopic			23d. Date of delive Month	ery Day Year
P.O.	that the death cer ed by the attendir detached for use	yslc	1 Yes 2 No	9☐ Unknown	eath 5 Other (speciny)			
	that hed by deta		Part II. Other significant conditions	contributing to death but not resu	ilting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
rds	w requires that s been signed t should be deta	ed by	hypertensie	~			1 🗆 Yes	2₽No 3□Prob	ably 4 Unknown
000	aw re	plet	<i>J</i> ·				24a. Was an	24b. Were auto	psy findings available
H	sician: The law scertificete has b lirector, page 2 s	Completed					autopsy performed?	death?	npletion of cause of
/ita	Physician: r this certifier ral director, I	Be	25. Was case referred to medical examiner?				ath (Check only one)		
5	Physic this o	ပ္	19€Yes 2□No		ER/Outpatient 3 [dome 5 Residence		y)
no	ding F h. After funer	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
Division of Vital Records,	Attending or death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e age Blace of Injury. At he			28f. Location (Street a	and Number or Rura	I Route Number,
Ę	at or s s after ii Dire	Sert	4 Homicide	building, etc. (Specify	')		City or Town, Sta	te)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	edical C	(Check only 2 Medical Exar	nysicien: To the best of my knowniner: On the basis of examinat	wledge, death occurre	d at the time, date and place on, in my opinion, death occ	e, and due to the cause(urred at the time, date a	s) and manner as st nd place, and due to	tated. the cause(s)
	thin 2 the the implet	Med	one) 29b. Signature and title of certifier	and manner stated.		9c. License number		ate signed (Month,	
	F 3 F 8	EF.	1 Bul D	0.0		01957	7		2 9 9 6
j	11/		30. Name and address of person who		23a) (Type, Print)	11100	Jan	may s	7 2 2 6
4	10		Brad Graus	1.4	of Ma	Island Medic	I Contain		
2	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture Societies				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WILLIAM M. BRISCOE, SR. JANUARY 9 2006 9:49A. /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/04/1939 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 213-36-1939 66 Director MD Usuat Residence of Decedent the Maryland 10c. City, Town or Location worle 10a. State 10d. Inside City Limits 7 is marked other than "naturel", or Items 23a or 28a-f ehov traumatic event, the Medical Examinar must be notified at MDBALTIMORE 1X Yes 2 □ No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 3561 LYNDALE AVENUE 21213 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GROCERY CLERK SUPER-MARKET 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) in and 2 should be fit. Health and Mental H JULIUS BRISCOE AUDREY JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and important: if item 27 is rr any injury or other traum WILLIAM M. BRISCOE, JR./SON 3561 LYNDALE AVENUE, BALTIMORE, MD 21213 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 X remation 3 Removal Irom State METRO/BALTO CEM 1/12/06 4 □Donation 5 □ Other (Specify) BALTO., MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee ames 1701 LAURENS STREET, BALTO., MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LARYNGEAL CANCER **Physician** years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of) Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case relerred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After Natural 2 Accident Injury 5 Pending 1 Tes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and line of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEMAG CHAPLUES 6601 N. Charles Ir Sommere W 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 0 Registrar

	Director		189–18–5253 Usual Residence of Decedent 10a. State 10b. County		83 Yrs.	Location		8-4-19	922 P	A 10d. Inside City Limits	
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	r 28a	rec	10e. Street and Number	Inder	OZCH B	10f. Zip Code)		10g. Citizen of What Co	ountry?	
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036	be filed within 72 hours after death with the Maryland nial Hygiene. bd othar than "natural", or items 23a or 28a-f show evant, it a Medical Exercities trais the notified at	by Funeral Director	11. Marital Status 1 Never Married **Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 12 Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13	. Was Decedent of If Yes, specify Control of the second o	f Hispanic Origin? (Si uban, Mexican, Puert lo <i>Specify</i> :	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.	
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ylar	should be nd Menta marked umatic ev	10	Joseph H. Boyer					E. Rocke	•		
Mar			19a. Informant's Name/Relationship						r, City or Town, State,		
	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		Mrs. Arlette F. I 20a. Method of Disposition	Boyer / Wife	20b. Place of Dis	position (Name of	ore Annapo		.; Glen Bu		
E O	Pages nent of int: if i		1 ⊠Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spec						Crownsvil		
Baltimore,	permit. Pages 1 and Department of Healt Important: if Itam 2 any injury or other once.		21. Signature Fund al Service Liu	nsee		22. Name and Add	fress of Facility Si	ngleton	Funeral Ho	me, PA	
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Ö		by Pr	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
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Records, P.O.	The law requires ate has been sign page 2 should be	Be Completed	25. Was case referred to medical examiner?	Hospital:			Ythor	perform 1 ☐ Yes th Check only or	med? prior to death? 1 Yes	completion of cause of	
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BOYER, BRUCE N.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Florence R. Clark Jan 2006 0445 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Hospital Harford Bel Air If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) South 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2√2 F Yrs. 220-20-9898 90 Director Sept.14,1915 Carolina Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-fehov the Medical Examiner must be notified at 1 Yes 2 Xio Director MD Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1337 Willow Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2√2 No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ie marked other then Elementary/Secondary (0-12) College (1-4or 5+) Beautician Hair 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be and Mental es 1 and 2 should b of Health and Ments ? item 27 is marked Henry Lawrence Bessie E. Westbury ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 Chestnut Street Delta PA 17314 Ann Mason /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: if ite any injury or ot ang injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 1/10/06 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service License Ave. Baltimore MD 21221 Onne 300 Mace 23a. Part1. Enter the disease complications that caused the dishock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** re Dry Vascu disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner signed by the attending physicien and does detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregoent 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown xemia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? tai rena LVE 1 Yes 2 1 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2€ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manney 1 Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

The law requires that the death certificate be executed or Attending Physicien: death.

Maryland 21215-0036

Baltimore,

Director: within 24 hours after d
To the Funerei Direct
Completely filled in by filled in by th e

31. Date filed (Month, Day, Year) State Registrar

Medical

1 Natural

2 Accident

3 Suicide

(Check only one)

29a. Certifier

5 Pending

JAN 1

0

investigation

6 Could not be determined

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Régistrar's Signature

29c. License number

1 Decritiying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐Yes 2 ☐No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number. City or Town, State)

		-	For State Registrar		State	of Maryla		artment of H		and M		gien	. 0 0 0	00244
			Decedent's Name	(First, Middle,	Last)						2. Date of De	ath		3. Time of Death
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7 -	Funeral		5. Social Security No		6. Sex		. last birthday)	If Under 1 Year	If Under		8. Date of Bir (Month, Da	th	Q Ri	rthplace (State or Foreign ountry)
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	ems	Funeral	11. Marital Status		Armed	ecedent Ever in Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Ori an, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Whi	
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Maryland	s 1 and 2 should b Health and Ment Item 27 is marked other traumatic e	F	19a, Informant's Na				19b. Maili	ng Address (Street					or Town, State,	Zip Code)
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Division	Atte	tifle	3 Suicide 4 Homicide	6 ☐ Could n determi	ned 289. P	ace of Injury - At	home, farm, st	reet, factory, office			28f. Location (Rural Route Number,
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Amend item 11 per fib 851 1-13-06 yt
State of Maryland Department of Health and Mental Hygiene) For State Registrar 1-Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2206 1130 Jan /Medical Facility Name (If not institution, give street and number) 46. Town, or Location of Death 4c, County of Death Examiner Health Ke 12/ Air AV Hortord If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 F 1929 Mari Director 217.26.432 . 12. Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 5 I and a second of the second 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 CORDET Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Yes Give Specify)HILE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) + BUT MAKE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 2 JAJE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number Lity or Town, State Zip Code) 21078 1 00 HORVE DE GRACE, MID IES IER MAN DNIGHTE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit Pages Department of h Important: If it eny injury or o once. 1 Burial 2 Cremation 3 Removal from State CHARL 4 ☐ Donation 5 ☐ Other (Specify) TWO RN 22. Name and Address of Facility EVANS 21. Signature of Funeral Service Licensee - DEL AIR CHAPEL FUNTERN 01220 FORE MD 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line; Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** about /Medical Months Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical the attending IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 2 Fetal death ₫ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Ö detached 9 Unknown ģ ۵. signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 24 No 3 Probably 1 Yes 4 | Unknown certificete has been s rector, page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 25 NO 1 Tyes 1 Yes 2 -NO Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: Other: Certification: To 1 🗌 Yes 2 000 1 🗌 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 3 DOA After this 27. Man er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) nuar 30. Name and address of death (Item 23a) (Type, Print) of person who c moleted caus 0 31. Date filed (Month 32. Registrar's Signature Pay, Year) 0 2006 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 955 AM DAG 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner SVILLE HARFORS IARREI If Under 24 Hrs. 8. Date of Birth
| Month, Day, Year) If Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** 10 M 20 F 575.36.4436 KINTUC Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director -larfort ARRE TSUILL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a 21084 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify Specify: WHILE 3 ☐ Widowed 4 ☐ Divorced 'natural'. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If I fem 27 is marked other then any injury or other traumatic avant steems Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2752 AZUE MD 21084 DORDIHU MILE ARRET Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State HILLY * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ways Funt Ral CHAPEL BELLIR M01220 23a. Parti. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Little by one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** MONT resulting in death) /Medical Due to (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as/a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): O. Box 68760, Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy ō Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 1 No 3 Probably 4 □Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 1 Yes 2 No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral dir this 27. Mann J Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Division 1 Natural 5 Pending To the Hospitel or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and utto of certifie 29c. License number 29d. Date signed (Month, Day, Year) nd address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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31. Date liled (Month, Day, Year)

JAN 1 0 2006

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Cofsky Katherine 1:15PM January 9, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Apt. 104 Pleasant Ridge Dr. 227 Owings Mills Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 MX2 F Hours 578-28-5464 Director Yrs. 86 Nov.16,1919 W. Virginia Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, the Medical Examinar must be redified at MD Baltimore 1 Yes XXNo Director Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Pleasant Ridge Dr. Apt.227 21117 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify 3 Widowed Wivorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7: th and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Cook Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mike Jacobowski Olesska Kolass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun <u>once.</u> Linda Schindler / Daughter 5136 Schalk Rd. #1 Lineboro, MD 21102 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. * 4 ☐ Donation 5 ☐ Other (Specify) 1/12/06 Baltimore, MD 21. Signature of Line al Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician -0 ronary disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Aurtic STENUS! Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit perten Due to (or as a consequence of): Box 68760, attending physician Physician/Medicai as the l IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 PNo Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 24 No 1 🗌 Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 2 No filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending death, 1 Yes 2 No 2 Accident investigation after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the desist) of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (flem 23a) (Type, Priot) Street 750 MAIN Sule 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar 2006

Month **Physician** 00 Œ /Medical 4b. City, Town, or Location of Death 4c. County Name (If not institution, give street and number, **Examiner** BALT IMM (8. Date of Birth (Month, Day, Ye1/956 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 10 M 20 F 9 711 Director July Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23s or 28s-1 show any injury or other traumatic event, the Madical Examinat must be notified at once. 10a, State 10b. County 10c. City, Town or Location ND Anne Arundel Baltimore Direct 10g. Citizen of V 10f. Zip Code 21226 8045 High Point Rd. U. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rac 11. Marital Status 1 TYes 2 No. 1974-1979 If Yes, Give 1974-1979 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of B Elementary/Secondary (0-12) College (1-4or 5+) Army Mil 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnan Anthony J. Cadden, Jr. Ruth S. King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Dorothy Cadden, wife 200 5th Ave. Baltimore, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location 20a. Method of Disposition 1-26-2006 1 Burial 2 □ Cremation 3 □ Removal from State Arlington National Cemetery 4 □ Donation 5 □ Other (Specify) Arling 22. Name and Address of Facility
Ambrose Funeral Home, Inc. 21. Signature of Figure 1 Service Licensee 1328 Sulphur Spring Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** piratory /Medical Due to (or as a consequence of) Examiner lmonan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of); To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760,

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Arbutus IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Dat 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Mo 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use cont 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Oth 1 Yes 2 No 2 ER/Outpatient 3 00A 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occur Injury 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Numb City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year DANIEL EDWARD COHAN 8:24 A M January 07 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Baltinore N/A Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Yrs 216-12-0357 Director 85 12/19/1920 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iteme 23a or 28e-f ehow amy rightry or other traumatic event, it is Macalleal Exa cliner could be notified at once. MD N/A BALTIMORE by Funeral Director 1X Yes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3021 FALLSTAFF ROAD APT. #501 21209 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 MYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 Tes 2 No WHITE 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE FINANCIAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LOUIS **AUGUSTA** FRADKIN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILDRED COHAN / WIFE 3021 FALLSTAFF ROAD APT. #501 - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE HEBREW CONG 01/09/2006 REISTERSTOWN, MD 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature Funeral Service Licensee 8900 REISTERSTÓWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis I Weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed res 2 No certificate has 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MA ammin. D42561 Ó 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Passen, Min 21 Crossroads Drive #400 Owings Mills, MI) 21117 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Ma		d / Depa	rtment of F	lealth and	Mental Hyg	iene 006	00250
	Physici /Medic Examin	cal	Decedent's Name (First, Middle, La D	illip	DIC	eter	rich	r Location of Dea	2. Date of Deat Month	h Day Year	3. Time of Death
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Manhand	a-f show	ctor	10a. State 10b. County MD			Town or Loc					10d. Inside City Limits 1 💢 Yes 2 🗆 No
din di	3a or 28	Funeral Director	10e. Street and Number 505 NORTH SCH	IROEDER S	STREE	EТ	10f. Zip Code 2120	1	1	0g. Citizen of What Co USA	ountry?
OSO OSO	ai', or items 2	by	11. Marital Status 1) Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 Yes, Give Year or Dates:	•		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 XNo	lispanic Origin? (an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
intillities, interpretable filed within 72 hours after death with the Maryland int. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other then "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Event natimal be notified at	giene. er then "natur , the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		5+)	(Give I life. D	ent's Usual Occup kind of work done O NOT use retired	eation during most of wo d)	prking	16b. Kind of Business/	/Industry
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	ete hes page 2	Completed	Atrial	Fibrilla-	tion				-	ry prior to death? No 1 □ Yes	utopsy findings available completion of cause of
or vital	Attending Fritystelan: It death. Sector: After this certification by the funeral director.	To Be	25. Was case reterred to medical examiner? 1 Yes 2 □ No	Hospital: 1 ☐ Inpation		ER/Outpatien	3 □ DOA Oth	ner: 4 🗆 Nursing		ence 6 Other (Spe	city)
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	within 24 hours after death to the Funeral Director: completely filled in by the									n, State)	
	within 24 ho To the Fun completely f	Medical	29a. Certifier 1. Certifying PI (Check only 2 Medical Exerone) 29b. Signature and title of certifier	niner: On the best and manner st	of examinat	ion and/or inv	estigation, in my o	ppinion, death occ	curred at the time, d	ause(s) and manner as ate and place, and due	to the cause(s)
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th-	4		30. Name and address of person who	hi 100	death (Item	thed	ral Str	reet P	Ballina	He, MD	21201
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		•	1 - State Registrar		artment of Health and Mertificate of Death	fental Hygier		00251
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	/Medic Examin	_	4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Death		4c. County of Death	
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	yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L				10d. Inside City Limits
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumatic event, I're Mudical Examination that the motified at another.	d by Funeral Director	1 Never Married 2 Married 1 Yes,	Forces? s 2⊠No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 DHNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Black	
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Marylan	uld be fill Mental Hy Irked oth	To Be	17. Father's Name (First, Middle, Last) Jerome Diggs		18. Mother's Nam June	e (First, Middle, Maid	den Sumame) LUAK	
	and 2 should selth and Men n 27 is marke		19a. Informant's Name/Relationship (Type, Print) Lisa Diggs/Wife		ing Address (Street and Number or Rur osewood Lane DW		•	Code)
ē	Pages 1 an nent of Heel int: if item 2 iry or other		20a. Method of Disposition 1 Substitution 2 Cremation 3 Removal from	m State	ematory or other place)		. Location - City or Ti	
altin	permit. Page Department of important: if any Injury of once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Kirly Mer	101 10			11.2
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og	Physician		shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition	n each line.	ic Cardiomyopathy	or respiratory arrest,		Interval Between Onset and Death
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Vital	nysician: Th nis certificate director, pag	Be	25. Was case referred to medical examiner? Hospital:		Other	h (Check only one)		
٥٥	ng Phys ter this neral di	n: To	27. Manner of Death 28a. Da	Inpatient 2 ER/Outpatient e of Injury 28b. Time Injury 28b. Time	#IL 3L DOX 4 INUISING HE	ome 5 Residence 28d. Describe how in		(y)
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)	with To I	Σ	29b. Signature and title of certifler	D Philip C. Ditton	29c. License number P1969		Jan 5,	
	10		30. Name and address of person who completed c	ause of death (Item 23a) (Type	, Print)			
	\ Sta	ite		. Registrar's Signature	h Greene St. Ba	Himme M.	D 21201	
	Regist	rar	JAN 1 0 2006) / - / - / - / - / - / - / - / - / - /				
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1.	1	30. Name and odress our erson	who completed cause of	death (Item 23a) (Type.	Print)	00631	10 1	11100		
6		Matthew McA	ndrew	18101 Prin	ce Philip	Drive	Olner	L MD 2	25808	
	ate	31. Date filed (Month, Day, Year)	Ma h	trar's Signature	A.		- · · · · · · · · · · · · · · · · · · ·	1,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#20b c.perf H (351 1/1/7/06 TT

State of Maryland / Department of Health and Mental Hygiene 0 0 6 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MUNEY Physician 653 P PAUL 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, 10wn, 5.

BACTIMORE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day,
The Company of the Compa 4b City Town or Location of Death Examiner BALTIMORE CITY GOOD SAMARITAN HOSPITAL 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10M 20F 217-40-453 Yrs. MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10h County in then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director m0ALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21214 USA 3017 WESTFIELD AUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ 165 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced WHITE Completed . 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. importent: if item 27 is marked other then "na any injury or other traumatic event, the Made once. Elementary/Secondary (0-12) College (1-4or 5+) UPERVISOR CONSTRUCTION 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1400 HUICE ESSEL Illiam 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3017 AUE HARMAINE ARUELL -DAUGHICR WESTFIELD BACTMORE, MO 21214 Location - City or Town, State Glen Burnie 20b Piace of Disposition (Name of Date 20a. Method of Disposition YUMUNAC 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CEMETRY 13, 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service Licensee 22. Name and Address of Facility CHAPEL EVANS FUNGRAC PARKUILLE MODI234 RO. 8800 MARFORD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE **Physician** MYOCARDIAC INFARCTION disease or condition resulting in death) /Medical Examiner CORONARY ARTER' Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use es the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ф 9 Unknown 9 Unknown signed I Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à UBSTRUCTIVE PULMONARY 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 Hospital: 1 Inpatient ER/Outpatient 3□ DOA 1 ☐ Yes No 2 this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours efter deat To the Funarel Director: 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar KERITH

31. Date filed (Month, Day, Year)

J04E7#

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32 Registrar's Signature

DHMH 17 Rev 1/2001

BUD

BALTIMORE, MD

LOCH RAVEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death A 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Van 2006 /Medical 4c. County of Defailh 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** OSDITA If Under 1 Year 9. (Birthplace (State or Foreign Country)
South Carolina 6. Sex last birthday 8. Date of Birth (Month, Day, **Funeral** Days Hours 1□M 20%F 217-22-940 Usual Residence of Decedent Director filed within 72 hours after death with the Maryland 10b. County 10a. Slate 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 □ No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 625 Completed by Funeral or itema 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify 3 NWidowed 4 □ Divorced "natural", 16a. Decedenl's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print laughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) SI tof Health : locenc 20c. Location - City or Town, State 20a. Method of Disposition 5 1 Burial 2 □ Cremation 3 Removal from State permit. Page Department of Important: if any njury or once. 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalus of Funeral Service Licensee 22. Name and Address of Home ral Balton Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit to the Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification; To Be Completed by 2 No 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No ē 1 Inpatient 2 ER/Outpalient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Chack only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year

DHMH 17 Rev 1/2001

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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				Department of Health and M Certificate of Death		iene 2006	00255
4	-x, 4		Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death
3	Physicia		HELEN E. FLEMING		Jan	Day Year 2006	10:55 PM
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	n
			St Agnes Hospital	Baltimore	0.00	NA	(Ch. La Propins
31	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Yrs.	8. Date of Birth (Month, Day,	Year) Co	nplace (State or Foreign untry) MD
200	Director		218 22 1943 1 1 M 280 F 88 Usual Residence of Decedent		05 - 14 - 1	7[[1010
	yland		10a. State 10b. County 10c. City, Tow	n or Location			10d. Inside City Limits
	Maried	ctor	MD BALTIMORE CATONS	VILLE			1 ☐ Yes 2 🗷 No
	or 28	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	untry?
	ath w	ral	104 WESLEY AVENUE	21228	anifu Van as No	USA 14. Race - Ame	ocan Indian
	items	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Bfack, White	
36	irs aft	by F	3 Mydowed 4 □ Divorced Year or Dates:	1 ☐ Yes 24 No Specify:		Specify: BL	ACK
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural; or tlems 23a or 28a-f show ont. Tra Medical Evat. ar must be notitled at	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work		16b. Kind of Business/	Industry
2	thin 7	nple	Elementary/Secondary (0-12) Colfege (1-4or 5+)	life. DO NOT use retired)		BALTO. CITY	8CH0013
7	filed with Hygiene. other ther		1 III Okiob John	18. Mother's Nam			3010013
and	ntal H	Be	17. Father's Name (First, Middle, Last) AUGUSTUS BAILEY	BEATRICE	HARRIS		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. I Health and Mental Hygiene witem 23 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event. The Medical Exam is an initial the notified at	٩		Mailing Address (Street and Number or Rui			Zip Code)
<u>≅</u>	and 2 sho satth and n 27 is m		BERNICE E. PLUMPHREY 10	4 WESLEY AVE. CAT	ONSVILLE,	MD 21228	
ē,	item 27		cemete	of Disposition (Name of ary, crematory or other place)	Date	20c, Location - City or	Town, State
Ë	Page: nent o int: if		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	US 01-10	.06 R	BALTO. MD	
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		21. Signature of Funeral Service License	22. Name and Address of Facility VAUGHN C. GREENE FUNE	RAL SERVI	CE	
<u>m</u>	207 # 9		Vangan H	5151 BAUD. NATE PIKE	BAUTO:	MD 21229	Approximate
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory and	est,	Interval Between Onset and Death
300	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Cultural to to consequence of the cons	pathy, NOS			7 days
4	Examiner			moma Nos			7 days
	*	her	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying				
V	cuted nd ransit	Examiner	that initiated events c.	al effusion			6 days
ó	rate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence	of):			7 days 6 days
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Box 6	The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	h 3 Ectopic pregnancy		23d. Date of de	*
	ie death the atte	icla	230. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	5 Other (specify)		Month	Day Year
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ord	w require been sig should b	Completed	Se 12 Une		-		utopsy findings available
3ec	e law has b	d m			24a. Was a autop: perfor	sy prior to med? death?	completion of cause of
Vital Records,		e Co	25. Was case referred to medical	26 Place of Dea	1 ☐ Yes th (Check only or		3 2 □ No
Ę		To Be	examiner? 1 Yes 2 No Hospital: 1 N Inpatient 2 ER/C	Other		ence 6 Other (Spe	icify)
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joi	Attending in death. ector: After by the funer	atlo	2 Accident investigation	M 1 Tes 2 No			
Division	or Att after de Directi in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (S City or Tow	treet and Number or R n, State)	ural Houte Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 12 Certifying Physician: To the best of my knowledge	ne death occurred at the time, date and place	and due to the o	ause(s) and manner a	s stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	ind/or investigation, in my opinion, death occu	rred at the time, o	late and place, and du	e to the cause(s)
	To the within To the complex	Me	29b. Signature and title of certifier	29c. License number	l l	29d. Date signed (Mon	
			· VIIII	058571		Jan 5	2006
	le		30. Name and address of person who completed cause of death (Item 23a	(Type, Print)	D 1 4	1.	2006
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	Caton Avenue	balte	more 1	rangiand
	St Regist	ate rar		1			
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ROBERT FRAZIER 06-0101 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. RKD Amend, Unpend item#1,23a,27,28a-f.perME,0856,6/27/06,11 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Robert Wesley Frazier IV JANUARY 9:51A 2006 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1211 N. CHESTER STREET BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) **X**□**X**M 2□ F 33 Director 214-15-8222 01 - 22 - 1972Maryland Usuat Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Md Baltimore Randallstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Iteme 23a 9912 Southall Road 21133 Funeral Pages 1 and 2 should be filed within 72 hours after death USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2V No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Specify: African-Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2/☐/No þ Specify 3 Widowed 4 Divorced "natural", American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) i2th Chef Self-Employed other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental is marked ပ W Frazier 'II Karen Darnyse Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau 9912 Southall Road, Randallstown, Md 21133 Karen D. Williams/mather 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MetroCrematory 1/9/2006 Baltimore, Md 21. Signature of Funeral Service Lice 22. Name and Address of Facility 9200 Liberty Road, Wylie F/H P.A. of Baltimore county Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List "nly cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Trazodone intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for se's consequence off: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death signed by the a d be detached for 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 WUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 → Yes 2 □ No certificate has t irector, page 2 s autopsy performed? 1 XYes 2□ No or Attending Physician: 25. Was case referred to medical examiner?
1 XYes 2 No director, Medical Certification: To Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 1 Inpatient 2 ER/Outpatient 3 DOA this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. Fnd 1/4/2006 Fnd 9:47 atm within 24 hours after death To the Funeral Director: A cumpletely filled in by the fi 1 ☐ Yes XX No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) 1211 N. Chester Street 4 Homicide Baltimore, MD House Hospital 1 Certifying Physician. To the best of my knowledge, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a: Certifler To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. JANUARY 5, 2006 w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemost Hilly 111 PENN STREET BALTIMORE MARYLAND 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ [] [] 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1505 PM JANUARL 2000 /Medical 4a. Fecility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner ALTIMORE U JOHN5 HOPKING HOSPITA N/A Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1₩ 2□ F Yrs. Director 63 213-40-2164 June 17, 1942 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Heelih and Mental Hygiene.
ant: if item 27 is marked other then "naturel; or items 23a or 28a-f ehow ury or other transitie event, the Madical Examiner must be coulded. Pasadena 1 ☐ Yes 2 X No Anne Arundel County Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 802 222nd Street 21122 USA Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XXes 2 □ No If Yes, Give Year or Dates: 1959–65 1 Never Married 2 Married 1 ☐ Yes 2 XNo Be Completed by Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore Elementary/Secondary (0-12) College (1-4or 5+) Gas & Electric Co. Cable Splicer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Vernon S. Frazier Carrie Lockner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, Maryland 802 222nd Street 21122 Kathleen M. Frazier Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment Importent: If any injury o Lake View Memorial Pk 1/12/06 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Tuneral Service Licenses Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 Alle Rant. Enter the disease, or complicate is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one calls so on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART FAILURE Physician UEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit Due to (or as a consequence of) ettending physicien Physiclan/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ğ Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No should be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificete 2 No 1 Yes within 24 hours efter death. To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 1 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

or Attending Physician:

Hospital

To the

Division of Vital Records, P.O. Box 68760

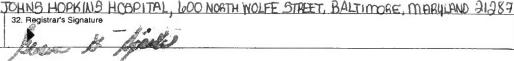
State Registrar

INUSTAPHA SAHEED

31. Date filed (Month, Day, Year)

Medical 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ORIGINAL

JANUARY 8 2006

			•	For State Registrar		5	State of	f Maryla				Health an Death	d Mental H	lygier Reg. I	200	6	00258	3
	. 8	Physicia	an	Decedent's Nam	e (First, Middle	le, Last)							2. Date of Month		Day	Year	3. Time of Death	
		/Medic		MARY	(f					FOX		and against of P	JANUA		6 200		1:50 A	A
	1-	Examin	er	4a. Facility Name (I HOSPICE					СТ	45.		or Location of E	eath		4c. County of		MODE	
		Funeral		5. Social Security N		6. Sex		7. Age (In y			nder 1 Year			Birth		9. Births	MORE place (State or Foreig	gn
	1	Director		216-56-		1 □ M	2 X F	95		rs. Mor	ths Days	s Hours I	07/01	Day, Yea 1910	a <i>r)</i>	Cou	MD	
		2		Usual Residence o	T			140-	0'1									
		the Marylar 28e-f ahow	۲	10a. State	10b. County		ND E	100.	City, Town								0d. Inside City Limit	
		outs after death with the Maryla elf, or Hama 23a or 28e-f ahor Examit at must be notified at	Funeral Director	MD 10e, Street and Nu		LTIMO	IKE		BALI	IMORE	. Zip Code			10g	Citizen of W	Ibat Cou	Λ	
		with	5	2452 FO		DEEN	DUVD				21209			, og.			My.	
AN		The 2%	era	11. Marital Status	KEST GI		. Was Dece	dent Ever in	n U.S.	13. Was E		-	? (Specify Yes or uerto Rican, etc.	No-	14. Race		can Indian,	
4	9	or ita	Fur	1 🗌 Never Marr	ied 2□ Mar	ried	Armed For 1 ☐ Yes If Yes, Giv				specify Cul		uerto Hican, etc.		Specify:	k, White,		
9	5-0036	72 hours after death with the Maryland natural; or itams 23a or 28e-f ahow dical Examination notified at	d by	3 Widowed	4 Divorced	t	Year or Da	ates:		101	S ZELINO	o specity.			Specify:	WIL.	I I E	
5	5-	"natu	Completed	(Spec	15. Deceden	nt's Educat est grade c	tion completed)		16a.	Decedent's (Give kind o life. DO No	I work done	e during most of	working	16b	. Kind of Bu	siness/In	dustry	
0	2121	filed within Hygiene. Ither than "	dmo	Elementary/Seco	ondary (0-12)		College (1	·4or 5+)	HO	MEMAKI		64)			OWN	номе	•	
t		Hygid other	Be C	17. Father's Name	(First, Middle,	Last)			110	TET BYTE	-11	18. Mother's	Name (First, Mic	dle, Maid				
9	Maryland	s 1 and 2 should be filed I Health and Mental Hyg Item 27 ia marked othe other treumatic avant.	To B	LOUIS						HARRI:		LEI					SNYDER	
0	Mar	d 2 sh th and 7 la m treum		19a. Informant's N				TED	1				r Rural Route Nu					
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0	ΘĒ			1 X Burial 2 4 □ Donation			noval from S	State R1	cemeter) ETH T	r, crematory - TI OH			08/2006	MOC	DLAWN	МГ	1	
9	altimore,	permit. Page Department of Important: If any injury or phore.		21. Signature of	1-	Licensee		10.				ress of Facility						
Ĭ	ä	Depared Important in police			/ass	1				8000	DEICI		OL LEVII					
-	45			23a. Part1. Enter t	tre disease, or	r complica t only one	tions that cause on ea	aused the d ach line.	eath. Don	ot enter the	mode of dy	ying, such as ca	diac or respirato	y arrest,	SVILL	L, 1	interval between	
		Physician		Immediate Cause disease or condition	nc		Cr	nge	Arr	e 10	car	t Fai	leur				Onset and Death	
	187	/Medical Examiner		resulting in death)			Due to (or as a con	sequence c	f):	/		lew lis ea					
J	4	Examinic	-	Sequentially list co	onditions,	b	Due to (or as a cons	erv	est.	hea	470	us ea				Jamo	
3.	V	nsit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	erlying injury	₹	k	+-	ae 1	en	in						Lears	
3 9	<u>_</u>	be executed sician and burial-transit	Exar	that initiated events resulting in death)	S	C	Due to (or as a con	sequence o	f):							1	-
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2	9	certifical nding phy use as th	Aedi	IE EENALE.														
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~	0.	the at	Physician/Medical	1 Yes 2			4☐Pregna 9☐Unkno	ant at time o	of death		r (specify)			_	Mon	101	Day real	
2	σ.	that the de ed by the detached		Part II. Other signi		ions contri	ibutina ta de	ath but not	resulting in	the underly	ing cause o	awen in Parbl.	23e. D	id tobacc	o use contri	ibute to t	he cause of death?	
OKMA.	Records,	requires that been signed should be del	d by	Lea	Cretes	me	elli	tun	, 1	2,	al f	ailu	10 1	Yes	2 No	3 🗍 Prol	oably 4 []Unknow	m
6	9	w req	iete						7					ras an	24b. W	Vere auto	psy findings availab	le
18		The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed						-				— a	utopsy erformed	? B	rior to co eath?	mpletion of cause of	
IT	Vital		0	25. Was case refe	rred to medica	al						26. Place of	1 ☐ Ye		NO I	Yes	2 No	
	of Vi	d is	To B	examiner?	(No	Hos	spital: 1 🔲 li	npatient 2	2 ER/Out	patient 3[DOA)thor	ng Home 5 🗆 F		6 the	r (Speci	11/25/10	
27	o uo			27. Manner of Dea	th 5 □ Pendii	ing	28a. Date of (Mont	of Injury h, Day Year	28b. T	me of jury	28c. Inju		28d. Descr	be how in	njury occurre	ed	0	-
D	visio	Attending r death. ector: After by the fune	cati	2 ☐ Accident 3 ☐ Suicide		tigation				M		□Yes 2□No	T and I are	(0)				
7	Öİ	in the c	Certification:	4 Homicide	detern		28e. Place buildir	of Injury - Ang, etc. (Sp.	at nome, tai ecify)	m, street, ta	dory, office	θ	City or	Town, St	and Numbe ate)	er or Hur	al Route Number,	
1	_	spitel or nours afte neral Dir filled in	ai C	29a. Certifier	1 Certifyin	ing Physic	ian: To the	best of my	knowledge	death occu	rred at the	time, date and p	lace, and due to	the cause	e(s) and mar	nner as s	tated.	
1		To the Hospitel within 24 hours a To the Funeral completely filled	ledical	(Check only one)	2 ☐ Medical	I Examine	r: On the ba	asis of exam	nination and	Vor investig	ation, in my	opinion, death	occurred at the til	ne, date :	and place, a	ind due t	o the cause(s)	
		To t To t	Σ	29b. Signature and	title of certific	er Ha	2. 2/		las	0		nse number	5		Date signed			
	,	1	- 9	30 No.	MA	10 cer	eted caus	201	Itom 2021	Time Date:	20			1	11019	7	-/	
		8		30. Name and add	less of person	(ey)	Gaus	SINC	(Jan 23a)	20(/	V- CV	rules a	St. Ba	lto.	nud.	21	204	
		Sta Registr		31. Date filed (Mor	AN 1 n	2006	32 R	egistrar's Si	ignature	Carle	,							

			1 - For State Registrar	State of M	aryland /		artment of I rtificate of			-	giene Reg. No.	006	00259
	Q.		1. Decedent's Name (First, Middle	le, Last)				-		2. Date of De	ath Day	Voor	3. Time of Death
	Physici /Media		HELEN	F GRIFF	10					JAN	700	O 6	10-45A M
	Examir	ier	4a. Facility Name (If not institution	-			4b. City, Town,				4c.	County of Deat	
			Howard County G 5. Social Security Number		Ltal je (In yrs. last l	himbodo.s		umbia		O Data of Bi-		Howar	
	Funeral Director		234-03-0013	1 M 2 N F		Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da Sept 2	Y Year)	919 Wes	hplace (State or Foreign untry) t Virginia
			Usual Residence of Decedent					1		верь 2	J, 1.	JIJ WES	t virginia
	nylan how		10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
	e Ma	cto	Maryland Howa	ırd		Colu	mbia						1 ☐ Yes 2 X No
	or 2	Dire	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Co	untry?
	s 23a	ral	7080 Cradleroc					045			US		
9	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic evant. The Moulcal Examination ust be notified at	Funeral Director	11. Marital Status 1 Never Married 2 Mar	If Voc Cive Z			Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2√☐ No	an, Mexic	an, Puerto F	cify Yes or No Rican, etc.)		4. Race - Ame Black, White	e, etc.
21215-0036	hours ural',	d by	3√ Widowed 4 □ Divorced	Year or Dates:	1							Specify: Wh	
15-	n 72 "nat	Completed	(Specify only highe	it's Education st grade completed)	16	(Give	dent's Usual Occup kind of work done DO NOT use retire	during me	ost of workin	g	16b. Kin	nd of Business/	Industry
112	filed within Hygiene. other than "	dwo	Elementary/Secondary (0-12)	College (1-4or	5+)		ident Ma	,			Ar	oartmen	ts
	Hygie other	a)	17. Father's Name (First, Middle,	Last)						(First, Middle,			
lar	ould be Mental arked o	To B	William A. Sh	aretts					Mary	Agnes :	Phill	lips	
Maryland	2 should and Men is marke aumatic		19a. Informant's Name/Relations	ship (Type, Print)	19	9b. Mailir	ng Address (Street	and Num	ber or Rural	Route Number	er, City or	Town, State, Z	ip Code)
	1 and 2 Health tam 27 i		Ronald R. Share	etts, Son			Puritan	Aver	iue La	s Vega	s, NV	7 89123	
ore	0 0		20a. Method of Disposition 1 Darial 2 Xcremation	3 □Removal from State	20b. Place cemet	of Dispo tery, crer	sition (Name of natory or other pla	сө)	Da	ate	20c. Loc	cation - City or	Town, State
Ħ.	Pa Int:		'4 □ Donation 5 □ Other (S	Specify)	Metro		ematory :						Maryland
Baltimore,	permit. Departr Imports any inju		21. Signature of Funeral Service. Thomas Greg	Chr		Ž	Name and Address remation 99 Frede:	ss of Fac Soci rick	ety 0 Road	f Mary Baltim	land ore,	Inc. Maryla	nd 21228
			23a. Part1. Enter the disease, or shock, or heart failure. List		Approximate Interval Between								
	Pnysician		Immediate Cause (Final disease or condition	META		1	CAN	CER	. 70	400	SC, 9	CIUE	Opport and Dooth
	/Medical Examiner		resulting in death)	Due to (or as	a consequence								2.173
	LAdiminei	_	Sequentially list conditions,	b. SEPS									DAYS
	ed sit	olne	Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Cause (Disease or injury		a consequent	,	ARTER		n' com	00-		***	
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. CORO Due to (or as	a consequence		1127ER	Υ	DISE	417E		-	4000
68760,	e be e	calE		d									
89		ledical	_	0.									
ŏ	death certificate be attending physic	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		th 3	Ectopic pregnanc	.,			23	3d. Date of deli	very
O. B	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at			Other (specify)	,				Month	D <i>a</i> y Year
م	that the		Part II. Other significant condition	ons contributing to death b	ut not resulting	in the ur	nderlying cause giv	en in Par	1.	23e. Did to	bacco us	e contribute to	the cause of death?
Vital Records,	sign sign d be	ed by								1 🗆 \	′es 2 🗆	No 3□Pro	obably 4 Donknown
000	law requas been 2 shoul	Completed								24a. Was		24b. Were au	opsy findings available
Ä	0 5 0	mo;									rmed?	death?	ompletion of cause of 2 No
/ita	i cian: Th certificate rector, pag	Bec	25. Was case referred to medica examiner?							(Check only o	ne)		
of V	Physician: this certific ral director,	To.	1☐ Yes 2☐ No	Hospital: Inpatie			t 3□ DOA Ott	ler: 4 □ N	lursing Hom	e 5 🗆 Resid	lence 6	□Other (Spec	ify)
	ding h. After fune	Certification:	27. Manner of Death Natural 5 Pendir 2 Accident investig		ry y Year) 28b.	. Time of Injury	28c. Injui Woi	yat k? Yes 2[28	Bd. Describe h			
Division		rtifica	3 Suicide 6 Could 4 Homicide determ		ury - At home, c. (Specify)	farm, str	eet, factory, office		21	Bf. Location (S City or Ton		Number or Ru	ral Route Number,
	spital ours ieral filled		29a. Certifier 1 Certifyin	ng Physician: To the best	of my knowledg	no doath	a coourned at the time	mo data s	and place, or	ad due to the			
	To the Hos within 24 h To the Fun completely	Aedical	one)	and manner sta	f examination a	and/or inv	estigation, in my o	pinion, de	ath occurred	d at the time,	date and p	olace, and due	to the cause(s)
	To To Con	Σ	29b. Signature and title of certifie				29c. Licens	e number				signed (Month	,
,	`			tem)			000	53	150		JAn	170n	2006
	\		30. Name and address of person Shawwar Ac				Print) SANTIA	60	ROA	H) C	°(1) - 7	TE IIC	
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature			40		(01)	20	AM	0 2045
	Registr		JAN 1 0 2006	March A	Acea	Se de					70	, , , , ,	- 4043

			Ple				/ Depa	rtmen	t of H	Ensure A	-		_	00260
	Physici		Ragistrar 1. Decedent's Name (First, Mid Donald Luther				Cei	titicat	e of l	Death	2. Date of Dea Month January	Day		3. Time of Death
1	/Medic Examir		4a. Facility Name (If not instituti 1117 Quantril 1	_	and number)			-		Location of Death			County of Dear	
286	Funeral Director		5. Social Security Number 234 40 7034	6. Sex 1 ½ M 2		je (In yrs. las 7	t birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Aug. 3, 1	h y, Year) 928	9. Bir Cc West	thplace (State or Foreig buntry) Virginia
	Maryland f show	ior	Usual Residence of Decedent 10a. State 10b. Coun Maryland	ty		10c. City, 1	fown or Lo							10d. Inside City Limit
	h with the	Funeral Directo	10e. Street and Number 1117 Quantril 1	Way	•	1.		10f. Zip		5		10g. Cit	izen of What Co	puntry?
920	72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show olfsel Examiner must be notified at	by	11. Marital Status 1 🔀 Never Married 2 🗍 Ma 3 🗍 Widowed 4 🗍 Divorce	Arried 1	as Decedent med Forces? XYes 2 Yes, Give ear or Dates:			Vas Deced Yes, spec		ispanic Origin? (Spanic Andrews) (Specify:	pecify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit Specify: W	
21215-0036	- * 3	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)		pleted) bliege (1-4or		life. I	lent's Usua kind of wo DO NOT u	rk done d se retired	durina most of wor			ind of Business.	·
	permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 le marked other then any njury or other treumatic event, Ins. M. 2016.	To Be Co	17. Father's Name (First, Middle Lon Ernest Gi					acor	er	18. Mother's Nam	ne (First, Middle,	Maiden		CICY
, Maryland	end 2 shou salth and M n 27 le mar	-	19a. Informant's Name/Relation Jimmie C. Gilme				7113	East	Bidd	and Number or Ru lle St. B				
Baltimore,	Pages 1 tment of He tant: If iten jury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	(Specify)	al from State	cem		l Vete	rans	Cem. 1/1		Garr		rest, Md.
Bal	Departition Department Importment		21. Signature of Funeral Service 23a. Fari 1. Enter the disease,	Burl	ous	le		407	OLC	ss of Facility ki Funera Eastern /	venue E	ssex	k, Md. 2	21 221 Approximate
H	Physician /Medical		Ib ck, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	st only one cau	Due to (or a	10 Caro				sen Sease		1651,		Interval Between Onset and Death
68760,	The law requires that the death certificate be executed be the steen signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	} b	Due to (or as	a consequer	ce of):	tery	di.	sease				25 y ears
P.O. Box 6	that the death certific, ned by the attending pl detached for use as t	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1(Live birth	of pregnance 2 Fetal de t time of deat	eath 3	Ectopic pi Other (sp					23d. Date of del Month	ivery Day Year
	quires that n signed by	ρ	Part II. Other significant condi	tions contribut	ing to death b	out not resultii	ng in the ur	nderlying o	ause give	en in Part I.	23e. Did to			the cause of death?
Records,	ilcien: The law requir certificete has been si rector, page 2 should	Completed									24a. Was autop perfor 1 Yes	rmed?	24b. Were au prior to death? 1 Yes	utopsy findings available completion of cause of
Vital	ding Physicien: The h. After this certificete ha funeral director, page	Be	25. Was case referred to medic examiner?		N.				104	26. Place of Dea		-		
of	Phys r this ral dii	5	1 ☐ Yes 2 🛣 No 27. Manner of Death	Hospita 28:	1 L Inpatie		VOutpatien Bb. Time of			4 Li Nursing H	ome 5 ★ Resid			cify)
Division of	Attending Par death. ector: After by the funera	Certification:	1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Coul	stigation	a. Date of Inju (Month, Da	y Year) jury - At home c. (Specify)	Injury	М		(? Yes 2 □ No		Street an	d Number or Ri	ural Route Number,
Ö	To the Hospitel or Attant within 24 hours after deatl To the Funerel Director: completely filled in by the	edical Ceri	29a. Certifier	ring Physician	: To the best	of my knowle	edge, death	occurred	at the tim	ne, date and place pinion, death occu	and due to the	cause(s)	and manner as	s stated.
	thin 2, the Pomplet	Med	one) 29b. Signature and title of certifi	aı	nd manner st	ated.				e number			e signed (Monti	
	F ≯ F 8		> Sul.	hollen									100 100	
6	f q	ato	30. Name and address of persons o	who completed with a soul	us V	AMHOS ar's Sign fun	10	Print)	rth (Greene S-	freet B	alt	imore l	MD 21201
	Registr		JANT	0 2000	A STATE OF THE STA		14							

State Registrar

KEVIN D. GOODNOE 06-0078 Unpend item Za, Z/, pen F, 351, 1/13/06 IT Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene **RKD** 00261 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** JANUARY 2006 2:27P EVIN /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Harford Belair <u>608 A Squire Lane</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 10 M 20 F -48.07 48 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 No Directo HARFORI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? -1014 Funerai filed within 72 hours after death Iteme ; Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ryes 2 No 5 Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE Be Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ERINIEL other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any lighty or other traumatic event pixe. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21004 MIL SING ABINGIA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗹 Cremation 3 Removal from State EVANO FUSTRAL /Z006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAREI Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Subarchnoid Hemorhage /Medical Due to (or as a consequence of): Examiner Rupture of a Berry Aneurysm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1/2 Yes 2 \(\times \) No 24a. Was an autopsy performed? 1 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 XOther (Specify) SCENE Medical Certification; To 1 XYes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. JANUARY 4, 2006 leted cause of death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE MARYLAND 21201 31. Date filed (Month, Day, Year) 32 egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 1

0 2006

Amend item#18, pentil, Type, 9/19/int in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State Registrar	State of Marylani		nt of Health and ite of Death		eg. No. 006	00262
Dhysisian	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month		3. Time of Death
Physician /Medica	Jessie Mae Galster				JANUAR	7/ 200	
Examine	Δ .			y, Town, or Location of Dea	th	4c. County of Dea	
	5. Social Security Number 6. Se			er 1 Year If Under 24 Hrs		AnneA	
Funeral Director		M 2K F 83		s Days Hours Min		922 SC	thplace (State or Foreign ountry)
Director	10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
TES in the Marylar in	MD Anne Aru	ndel G1	en Burnie				1 ☐ Yes ZZ No
6 Safety of the Market of the	10e. Street and Number			ip Code	1	0g. Citizen of What C	ountry?
th will	7928 Myers Drive			21061		U.S.A.	
C Gea	11. Maritaf Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Am Black, Whi	
1 8 8 1 E	3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 CXNo If Yes, Give Year or Dates:		2. No Specify:	, 5,0.,	Specify: W	
72 h 72 h	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decedent's Us (Give kind of w	ual Occupation rork done during most of wo use retired)	rking	16b. Kind of Business	/Industry
21215-00 ed within 72 ho ygiene. In the Medicals it, the Medicals	Elementary/Secondary (0-12)	Coflege (1-4or 5+)					
			Telephone	Operator	ma (First Middle A		one Company
Iryland 2 iled ind Menula be iled ind Menula be iled imaric event, Iro Re Co					^{me (First, Middle, M} E adie a (unknow		
Marylan da 2 should be the and Marylan and Mental in and Mental or traumatic eve To Be	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Addres	ss (Street and Number or Ri			Zin Codel
I DENE	Debra Lazo / Grand			cin Court; Se			Lip Godey
ife, N	20a. Method of Disposition	20b. Pl	ace of Disposition (Nametery, crematory or	ame of		21144 20c. Location - City or	Town, State
Page Page Dent on: If	1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	IGITIOVALITORI STATE		remation 1-6	-2006	Stevensv	ille. MD
Baltimore, permit. Pages 1 am Department of Heal Important: If tiem 2 any Injury or other	21. Signature of Funeral Service Lidens		22. Name a	and Address of Facility Second Ave SW;	ingleton	Funeral Ho	ome, PA
	23a. Part1. Enter the disease, or compl	ications that caused the death					Approximate
Physician	Immediate Cause (Final	ie cause on each ine.					Interval Between Onset and Death
/Medical	disease or condition resulting in death)	Due to (or as a consequ	ROTAL	INFARCT	TON		1 DAY
Examiner		Dao to (or as a consequ	onco ory.				
7/A	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):				
760, stoian and burial-transit	Cause (Disease or injury that initiated events	b					
9 exe		Due to (or as a consequent	ence of):				
68760, ificate be e: g physician as the buria		J					
OX 6	IF FEMALE:	0. 14					
Box aath cerr attendin for use	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal	death 3 Ectopic			23d. Date of de Month	ivery Day Year
P.O. Box 6876 hat the death certificate be by the attending physici letached for use as the bu Physician/Medical	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4 ☐ Pregnant at time of dea 9 ☐ Unknown	ath 5 Other (s	pecify)	16-9-		,
S, P. es that es that be detained by Ph. by	Part II. Dther significant conditions cor	tributing to death but not resul	ting in the underlying	cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds, quires n signi					1 X Ye	s 2 No 3 Pr	obably 4 Unknown
al Record The law requir cete has been si page 2 should					24a. Was ar	24b. Were au	utopsy findings available
The is page 2					autopsy perform	led? death?	topsy findings available completion of cause of
Vital Ficien: The certificete ector, pag	25. Was case referred to medical			26 Place of Dec	1 ☐ Yes 2	No 1 ☐ Yes	2 No
of Vi hysicia his cer il direct		ospitaf: 1 Ninpatient 2 E	R/Outpatient 3 D	Other		nce 6 Other (Spe	cufv)
on of Vita ding Physician: After this certific funeral director,		28a. ate of Injury (Month, Day Year)	28b. Time of Injury	28c. fnjury at Work?	28d. Describe ho		
isior wendin death. ctor: Aft y the furr	2 Accident investigation		М	1 ☐ Yes 2 ☐ No			
Division of Vital Records, teal or Attending Physician: The law requires the staffer death. The Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, facto	ry, office	28f. Location (Str City or Town,	eet and Number or Ru State)	iral Route Number,
pltal ours a seral c							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. Medical Certification: To Be Completed by Physician/Medical Examily	29a. Certifier 17 Certifying Physical Check only one)	sician: To the best of my know ter. On the basis of exammation and manner stated.	ledge, death occurred on and/or investigation	d at the time, date and place n, in my opinion, death occu	, and due to the ca irred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
To th withir comp	29b. Signature and title of certifier	1		c. License number	29	d. Date signed (Monti	h. Day, Year)
	Millign	fan MD	1	0060791	j	ANVARY	1,2006
'n	30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)				3 -0
. ,	30. Name and address of person who co WILLIAM HAN 31. Date filed (Month Day Year)	301 HOSPITAL	DITUE, 6	ign burnite	mo 21	230	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	Ire Company				

DHMH 17 Rev 1/2001

			For State Registrar	State of	Marylar		artment of H rtificate of L		lental Hygie Reg.	4000	00263
	Sharetai		1. Decedent's Name (First, Middle	Last)					2. Date of Death		3. Time of Death
	Physici /Medio) VI(3-	Ann	assign	ser) SWONY	Day 200 Yea	12:44 PM
	Examir		4a. Facility Name (If not institution,	- \	iber)		4b. City, Town, or	Location of Death		4c. County of De	
			Carroll Ha	Shis C	enter	Jana bint de N	Me.	If Under 24 Hrs.		(34	
	Funeral Director		5. Social Security Number 219-22-0296	6. Sex 1 □ M 2 💢 F	7. Age (<i>lin yr</i> s. 77	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye July 20,	ar)	Birthplace (State or Foreign Country) MD
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Mary f sho	ğ	MD Carr	n11		Sykesvi	110				1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number	311		ykesvi	10f. Zip Code		10g.	Citizen of What	Country?
	h with	a D	6709 Carroll	Highland:	s Road		21784			USA	
	dea	Funeral	11. Marital Status	12. Was Dece	dent Ever in U		Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ar	nerican Indian,
21215-0036	d within 72 hours after death with the Maryland Jene. r than "natural", or Items 23a or 28a-f show The Medical Examene out the Indiffed at	by	1 ☐ Never Married 2 [X] Marrie 3 ☐ Widowed 4 ☐ Divorced		2 [X] No		1 □ Yes 2 No	Specify:	Alcan, etc.)	Specify:	nite, etc. Thite
2-0	72 ho	ted	15. Decedent'	Education		16a. Dece	ient's Usual Occupa	ition	16b	. Kind of Busines	
21	within 7 ene. than "r he Med	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. i	kind of work done a DO NOT use retired,)		-	
	e filed w Il Hygier other th		12	41		nssem	bly Black			manufac	turing
Maryland	Q 20 20 9	o Be	17. Father's Name (First, Middle, L. J. Cooper Dorse	•					(First, Middle, Maid	,	
Ž	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	٢	19a. Informant's Name/Relationsh	7		19h Mailin	on Address /Street a		rie Minnio I Route Number, Cit		7's Code i
Ma	ith ar ith ar 27 is trau	1			1						
ē,	Pages 1 and nent of Heaith int: If Item 27 iry or other tr	- 1	Frank W. Gambe: 20a. Method of Disposition	t Husba	20b. P	lace of Dispo	sition (Name of	, D		Kesvill Location - City of	e, MD 21784 or Town, State
E			1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		tate		natory or other place	·	106	D ! 1	111 100
Baltimore,	그 된 원 등	1	21. Signature of Funeral Service L		DIU		ge Cemete Name and Addres		11824 Re		ille, MD
m	Depa Impo any ir		Jam B	Hine	,	Е	line Fune	ral Home	Reisters		
			23a. Part1. Enter the disease, or of the control of	omplications that canny one cause on ea	used the deatl						Approximate Interval Between
	Pirysician		Immediate Cause (Final disease or condition			<	Sepsis				Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	r as a conseq						1
И		-	Sequentially list conditions, if any, leading to immediate	b. — Due to (c	r as a consequ	uanaa af\.					
Т	ned nsit	nlne	Cause (Disease or injury	Due to (c	as a consequ	uerice or).					
Ć.	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (d	r as a consequ	uence of):					
68760,	ysicia ysicia	edical		d							
_	CD (0)		IF FEMALE:								
Вох	death certifi e attending od for use as	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outc 1 ☐ Live bir	ome of pregna th 2 □Fetal		Ectopic pregnancy			23d. Date of d	
P.O.	0 0 0	Physician/M	1 Yes 2 No	4□ Pregna 9□ Unknov	nt at time of de vn	eath 5	Other (specify)			Month	Day Year
	The law requires that the title has been signed by thoage 2 should be detached.	y Ph	Part II. Other significant condition	s contributing to dea	ath but not resu	ulting in the un	derlying cause give	n in Part I.	23e. Did tobacc	o use contribute	to the cause of death?
Vital Records,	quires in sign	ed by							1 ☐ Yes	200 3 DF	Probably 4 Unknown
000	aw requir s been si 2 should }	plet							24a. Was an	24b. Were a	autopsy findings available
Ä	The lav	Completed							autopsy performed	prior to death?	completion of cause of
Ita	ilcian: Th	ВеС	25. Was case referred to medical examiner?		0			26. Place of Death		40 1010	5 2 100
7	hys this of dij	ဂ္	1 ☐ Yes 2 ☑ No	Hospital: 1 In	patient 2	ER/Outpatient	3□ DOA Other	4 Nursing Hom	e 5 Residence	6 ☐Other (Sp	ecify)
Division of	ling F	on	27. Man or of Death 1 Natural 5 ☐ Pending		Injury Day Year)	28b. Time of Injury	28c. Injury Work		8d. Describe how in	jury occurred	
Si	Attending or death. ector: After by the fune	Cat	2 Accident investigated and Suicide 6 Could not	t be 280 Bloom	f Injune . At ho	ma farm str	M 1 □ Y	es 2 No	Of Leastine (Ctreet	(A) (
2	after after Direction by	Certification:	4 Homicide determin	ed building	g, etc. (Specify	r)	et, ractory, onice	2	City or Town, Sta	and Number or F Ite)	Rural Route Number,
	pspita hours ineral y filler		29a. Certifier 1 Certifying	Physician: To the b	est of my know	wledge, death	occurred at the time	e, date and place, a	nd due to the cause	(s) and manner a	s stated.
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical E:	caminer: On the bas and manne	is of examinat	ion and/or inv	estigation, in my opi	nion, death occurre	d at the time, date a	nd place, and du	e to the cause(s)
	To t withi To t	Σ	29b. Signature and title of certifier		0		29c. License		29d. E	ate signed (Mon	th, Day, Year)
			Xon	u grae	MO		100050	1943)2)	UNSALA 8	1, 2000
()	7		30. Name and address of person w	295 5+9	of death (Item	23a) (Type, F	Print)	ts winds on	er mo	21157	
	Stat		31. Date filed (Month, Day, Year)		girlar's Signat	ture			,		
	Registra	ar	JAN 1	0 2006	Melon	JE J	greek)				

			1 - For State Registrar		aryland /	Departm Certific			d Mental Hy	Reg. No	4000	00	264
ı	Physic	an	Decedent's Name (First, Middle, Las	,					2. Date of Do Month	aath Da	ay Year	3. Time o	f Death
1	/Medi	cal	Victoria Mary Gli 4a. Facility Name (If not institution, give						Januar	у4,	2006	3:40	A M
1	Examir	ner	Holy Cross Hospi				ity, Town, or 1ver S	Location of D	eath		County of Death		
	Funeral	_	5. Social Security Number 6. Se		e (In yrs. last b	oirthday) If Ur	ider 1 Year		Hrs. 8. Date of Bi		ntgomery	place (State)	or Foreign
	Director		578-36-3548	□M 200 F	81	Yrs. Mont	hs Days	Hours N	fin. 8. Date of Bir (Month, Da July 1	19, Year,	24 Free	olace (State ontry) man Va	L
	pu *		Usual Residence of Decedent 10a. State 10b. County		100 City To	wn or Location							
	Aaryla February February	ŏ	DC ISSUED									0d. Inside C	ity Limits 2 ☐ No
	28a-	rect	10e. Street and Number		wasni	Ington	Zip Code		· · · · · · · · · · · · · · · · · · ·	10a C	tizen of What Cour		2 140
	h with	Funeral Director	1320 C St NE				20002		,			•	
	deat	ner	11. Marital Status	12. Was Decedent	Ever in U.S.			spanic Origin?	(Specify Yes or No Jerto Rican, etc.)		ed State: 14. Race - Americ	an Indian,	
9	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2√1	No		specify Cuba s 2 🛣 No		ierto Rican, etc.)		Black, White,		
Ö	hours lural',	d by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:							Specify: Blad	CK	
15	n 72 n mat	Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed)	16	a. Decedent's U (Give kind of	Jsual Occupa work done d	ition fu <i>ring m</i> ost of i)	working	16b. K	find of Business/In	dustry	
712	iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5		lomemake		,		D.	wd		
פַ	e filec Il Hyg other	BeC	17. Father's Name (First, Middle, Last)			- Carcana Re	1	18. Mother's N	Name (First, Middle		rivate Sumame)		
/lar	uld be Menta rrked rlc ev	ToB	Oscar Smith					Rosa	Walker				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show eny Injury or other traumatic event, it is Medical Examinar must be inclified at once.	·	19a. Informant's Name/Relationship (7)		19	b. Mailing Addr	ess (Street a	nd Number or	Rural Route Numb	er, City o	or Town, State, Zip	Code)	
<u>ک</u>	and lealth m 27 her tr		Nancy G. Roberts	/Daughter				Vashing	ton DC 20	0002			
0	ges 1 it of H if its or ot		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemet	of Disposition (ery, crematory (or other place		Date		ocation - City or To		
Ξ	it. Pa rtmer rtant: njury		4 Donation 5 Other (Specify)	_	ME OII	vet Cem	-		12-06		nington I	C	
Ba	Depe Impo		21. Signatury of Funeral Service Licens	na	vis	22. Name	and Address Penn A	^{s of Facilit} Po Ave SE	pe Funera Washingto	1 Ho n DO	ome C 20020		
A.	Physician /Medical Examiner the prial-transit	licai Examiner	23a. Part.1 Enter the disease, or compishook, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if a.i.y, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	a. GASTROIN Due to (or as of SEPSIS	TESTIN. consequence	AL BLEE						Approximate Interval Bet Onset and I	ween
O. Box 6	The law requires that the death certificate be executed the has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deatl	h 3∏Ectopio 5∏ Other	pregnancy (specify)				23d. Date of delive Month	,	'ear
ds, T	signed to	þ	Part II. Other significant conditions con DECUBITUS ULCER	ntributing to death bu	it not resulting	in the underlyin	g cause giver	n in Part I.			ise contribute to th		
Ö	w require been si should b	etec	DECODITION OF CER						- ''	es 21	□No 3□ Proba	10iy 4 <u>20</u> 10	nknown
		Completed							24a. Was autop perfor		24b. Were aulop prior to con death? 1 \(\text{Yes}	npletion of ca	available ause of
<u> </u>	certif	Be	25. Was case referred to medical examiner?	lospital: vz			100		eath /Check only o	7.7			
5	r this	ဥ	1 ☐ Yes 2 ☒ No	ν⊾ Inpatier		utpatient 3 Time of		4 🗀 Nursing	Home 5 ☐ Resid)	
<u>.</u>	th. :: Afte	ţi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury M	28c. Injury Work?	es 2 □No	280. Describe i	OW INJUR	y occurred		
DIVISION	after dea	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc.	ry - At home, fa . (Specify)				28f. Location (S City or Tow	itreet and n, State,	d Number or Rural)	Route Numb	ber,
:	of the hospital or Attending Physicien: within 24 hours alter death. Othe Funeral Director. After this certifical Completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examin	sician: To the best of ner: On the basis of and manner stat	examination ar	e, death occurrend/or investigati	ed at the time	e, date and plan nion, death oc	ce, and due to the c curred at the time, c	ause(s) late and	and manner as sta place, and due to	ited. the cause(s)	
,	3	Σ	29b. Signature and title of centier	Tus	57 P	2	9c. License D4547				e signed (Month, E		
	3 0/		30. Name and address of person who co	mpleted cause of de	ath (Item 23a)	(Type, Print)							
			Yeheyas Neguosie M				ILVER	SPRING	MD 20910)			į
	Stat Registra	е	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Property 2							

			1_ For Stata	State of Marylan	d / Department of		•	-	00265
			Registrar 1. Decedent's Name (First, Middle, La	net)	Certificate of		Reg. N	2000	00200
	Physici /Medi		Theodore	Golds	mith		anuary		3. Time of Death 7 53 A M
	Examir	ner	4a. Facility Name (If not institution, gir	1_1_1	4b. City, Town,	or Location of Death		c. County of Death	. 6 . 6 .
	Funeral		,	SPLTO.		If Under 24 Hrs.	B. Date of Birth (Month, Day, Year	Baltin 9. Birthp	10 V C
	Director		213-10-4324	¹ X ^{™ 2□ F} 78	Yrs. Months Days	Hours Min.	(Month, Day, Year 4/01/1927	r) Couir	ntry) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location		W.	1	0d. Inside City Limits
	Mary s-f sh	tor	MD BALTIMO	RE	BALTIMOR	E			1 ☐ Yes 2 No
	ith the Marylar or 28a-1 show e notified at	Oirec	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Cour	ntry?
	s 23e	rall	7 SLADE AVENUE		21208			J.S.A.	
"	r Item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☑ Yes 2 ☐ No NAV	If Yes, specify Cut	Hispanic Origin? (Spec oan, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
93	72 hours after dea "natural", or Items	þ	3 Widowed 4 Divorced	If Aes, Give NAV Year or Dates:	Y 1 ☐ Yes 2 🗖 No	Specify:		Specify: WHIT	E
215-0036		Completed	15. Decedent's E (Specify only highest gr		16a. Decedent's Usual Occu (Give kind of work done life, DO NOT use retire	during most of working	16b. H	Kind of Business/Inc	dustry
212	filed withi Hygiene. other than	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	TELEVISION EN	,	BRC	ADCAST EI	NCINEED
pu	be filed ital Hyg d othe event.	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Name (MATINEEN
Maryland	2 should be filed withir and Mental Hygiene. is marked other than surnatic event.	2	ROBERT		DSMITH	MARY		U	NKNOWN
Ma	nd 2 sh Ith and 27 is n traun		19a. Informant's Name/Relationship (SHEILA GOLDSMIT		19b. Mailing Address (Street 7 SLADE AVENI				
Je,	of Health of Health fitem 27 r other tr		20a. Method of Disposition	20b. P	lace of Disposition (Name of emetery, crematory or other pla	Dat		ocation - City or To	
Baltimore,	0=:0		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci	Internoval from State	TH JACOB CONG.	01/08/	2006 FIN	IKSBURG. N	1D
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	nsee	22. Name and Addre	ess of Facility SOL	LEVINSON	& BROS	INC.
			23a. Part 1. Enter the disease, or com	plications that caused the death		TERSTOWN RO		SVILLE, N	ID 21208 Approximate
W	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	0		,,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	upince of):	0 /			
	Examine	<u>-</u>	Sequentially list conditions,	b. End S	tage he	nal D	15eas	se 1	lears
86	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0)
, 00	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):				
8760,	ate hy:	Physician/Medical		d					
Box 6	eath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of delive	rv
). B	e death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal 4 Pregnant at time of de		у		Month	Day Year
P.0	that the de led by the detached		9 ☐ Unknown Part II. Other significant conditions (contributing to death but not resu	ulting in the underlying cause di	ven in Part I	23e Did tobacco	use contribute to th	a cause of death?
Vital Records,	g be	ed by					1 ☐ Yes 2		
900	law requir as been si 2 should	Completed					24a. Was an autopsy		sy findings available
H	The ate h page	Com					performed?	death?	npletion of cause of 2 □ No
VIII:	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ I	STA CONTRACTOR OF	26. Place of Death (5	subacute
		\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury Wo	4 Nursing Home	d. Describe how inju	6 Other (Specify ry occurred	unit
Division	ten leat tor: the	catlo	1 Accident 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	1	M 1 🗆	Yes 2 □ No			
É	i Site	Certification;	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office	28	f. Location (Street ar City or Town, State		Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	ledical C	29a. Certifier (Check only one) Certifying Pt 2 Medical Exar	ysician: To the best of my knowniner: On the basis of examinat	wledge, death occurred at the tillion and/or investigation, in my o	me, date and place, and opinion, death occurred	d due to the cause(s at the time, date and) and manner as sta d place, and due to	ated. the cause(s)
	Fo the within ?	Med	29b. Signature and title of certifier	and mariner stated.					
)			Thristene Ki	Muhi Hosmil	tolut 62	912	Tein	uarula	2006
	10		30. Name and address of perso who	o mpleted ca se of deat (Item	23a) (Type, Print)	1 10	10		210000
	Sta	te	31. Date filed (Month, Day, Year)	5UBINWHC 32. Registrar's Signat	Foliat 62 23a) (Type, Print) 5401 OLd Course	ourtRoa	a, Keina	allstoi	NON
	Registr			06 Asser 25	A STATE				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANUARY 8, 2006 GREENBERG 2:15 A GLORIA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/01/1908 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F 105-28-2232 97 PA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at BALTIMORE BALTIMORE 1 ☐ Yes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 4204 OLD MILFORD MILL ROAD U.S.A. Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Efementary/Secondary (0-12) College (1-4or 5+) TYPIST FINANCIAL is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fill ont of Health and Mental H It: if itam 27 is marked off y or other traumatic even LAZEROW BESSIE NATHANSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8307 PRAIRIE ROSE PLACE-BALTIMORE, MD 21208 LOIS CHALAWSKY / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H.
Important: If its
eny injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MENORAH GARDENS 01/10/2006 SOUTHWEST RANCHES, FL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter le disea shock, or lan failur. Approximate Interv Between nse and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition nlewon **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months: 1 ☐ Yes 2 ☐ NO 4☐Pregnant at time of death 5 Other (specify) signed by the a o. 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but put resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed. certificate 1 ☐ Yes 2 ☐ No 1 Tyes 2 No 25. Was case referred to medical examiner? 26. Place of eath Check only one Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ 1√0 2 1 Inpatient 2 ER/Outpatient 3 DOA : After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 ⊟Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death, 2 Accident within 24 hours after death To the Funarel Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier CIPM 1, XZ8 Greene Tree se of death (ftem 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0 2009

			1 - For State Registrar	State o	f Marylan		ment of He		Mental Hygi	ene 0 0	6 0	0267
Ñ	Physici /Medi		Decedent's Name (First, Midd	C	LEOPA		itou		2. Date of Death Month		Year 06	3. Time of Death
	Examir	ner	4a. Facility Name (If not institution Howwd 5. Social Security Number		mber) Cuwrl 7. Age (In yrs. I	Hespital	b. City, Town, or Co Under 1 Year	Location of Deat	MD	4c. County of	Hou	
	Funeral Director		245. 56. 2441 Usual Residence of Decedent	1 ☐ M 2 조 F	93	Yrs. M	Ionths Days	Hours Min.		Year)	Country	e (State or Foreign NC
	Maryland -f show	tor	10a. State 10b. County MD HOWA			, Town or Locati	on				10d.	Inside City Limits 1 Yes 2 No
	with the	i Director	10e. Street and Number 10974 MILLBAN				10f. Zip Code 21044		10	g. Citizen of Wh	nat Country	?
980	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23a or 28a-1 show that the Medical Exercities the troubled at	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Was Decr	2 (X) No	If Ye		panic Origin? (S , Mexican, Puen Specify:	pecify Yes or No- o Rican, etc.)	14. Race	American White, etc	
21215-0036	be filed within 72 ho ntal Hygiene. of other then "natur event, tra Medical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12.14 GRADE	nt's Education est grade completed) College (1	-	(Give kind	's Usual Occupat d of work done do NOT use retired)	tion uring most of wo	rking	OWARD (ness/Indus	
Maryland	e d la be	To Be C	17. Father's Name (First, Middle, CHARLES PEDPLE						ne (First, Middle, M.	aiden Sumame)		
	nd 2 sh lith and 27 is m r treum		19a. Informant's Name/Relations			19b. Mailing A	ddress (Street ar		ral Route Number,	City or Town, St	ate, Zip Co	de)
Baltimore,	Pages 1 ar ment of Hea ant: If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State		on (Name of ory or other place EMORIAL	01 - 13		Columbi		
Balt	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral Service	Licenses	/	VAUG	ame and Address	of Facility	UERAL SERVISALTO MO	ICE		
68760,	Physician bhysician and physician and physician and Examiner transit the brutal-transit	dicai Examiner	23a. Part1. Ever he disease, o shock, or hart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a	ach line.	v tenji, ence of):					Int	pproximate erval Between set and Death
.O. Box (that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 The No 9 ☐ Unknown	1 Live b	come of pregnar inth 2 Fetal ant at time of de own	death 3 □Ect	opic pregnancy ner (s <i>pe</i> cify)			23d. Date of Month		y Year
<u>α</u>	w requires that the been signed by th should be detache	by	Part II. Other significant conditi	ons contributing to de	eath but not resu	lting in the under	lying cause giver	in Part I.	23e. Did toba 1 ☐ Yes	cco use contribu		ause of death?
al Reco	The law ate has b page 2 s	Completed							24a. Was an autopsy performe 1 ☐ Yes 20	prio	re autopsy or to comple th? Yes 2	findings available ation of cause of No
of Vit	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 🗆 l			DOA Other	4 🗆 Nursing H	th (Check only one)			
Division of Vital Records,	ding h. After fune	Certification;	27. Manner of Death 1	gation not be 28e. Place	h, Day Year)	ne, farm, street, t		es 2 □ No	28d. Describe how 28f. Location (Stre- City or Town,	et and Number		oute Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai C	29a. Certifier (Check only one) 1 Certifyir 2 Medical	ng Physician: To the Examiner: On the ba and mann	isis of examinati	rledge, death occ on and/or investi	curred at the time gation, in my opin	, date and place nion, death occur	and due to the cau red at the time, date	se(s) and mann and place, and	er as stated due to the	d. cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifie	ns —	1-4	(SO)	29c. Licensa	14183	290	. Date signed (/	Month, Day	, Year)
	10			NGER, D.C	. 545	O KNOL		H DR	SUITED	o con	IMBIL	7 MD
	Sta Registra		31. Date filed (Month, Day, Year)		gistrar's Signatu		E)				0	21045

State of Maryland / Department of Health and Mental Hygiene (00268 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year MARIE VANUAR /Medical 4a. Facility Name (If not institution, give street and num 4c. County of Death 4b. City. Town, or Location of Death Examiner RANDAUSTONN CEN'CH NORTHWEST HESPITHO BALTMONE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 07-01-1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Director 212.28.2520 15 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits treumstic event, the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2 No RANDALISTOWN MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 5 238 8 EVAT 21133 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SCHOOL TEACHER 12 TH GRADE 6 YRS BALTIMORE CITY 17. Father's Name (First, Middle, Last) . Pages 1 end 2 should be fil tment of Health and Mental H tant: if Item 27 is marked ott jury or other treumatic even 18. Mother's Name (First, Middle, Maiden Surname) JOHN S. GIBSON RACHEAL RUSK 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (HUSBAND) LEONIDAS HYMAN 8 EVATT COURT. RANDALISTOWN MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) **LIMAJGOOM** 01.07.06 BALTIMORE , MD 21. Signature of Funeral Service License 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE aughr 5151 BALTO. NATE PIKE, BALTO. MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SE Physician PSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physicien and Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Dav Year 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, CBSTANCTIVE 1 🗌 Yes 2 1No 3 Probably CTT/ZENT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificete TAIGINE MC TOURKER Yes 25. Was case referred to medi examiner? Be 26. Place of Death Check only one Hospital: ဥ 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3□ DOA this After thi 27. Manner of Death 1 望Natural Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funerel Direct completely filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL CONTE 13. CONANAN ERLANDO 31. Date filed (Month, Day, Year) 32. gtstrar's Signature State fresh Registrar JAN 10

DHMH 17 Rev 1/200

ORIGINAL

urs after death with the Maryland

For State Registrar

5. Social Security Number

023-05-4742

10a State

MD

10e. Street and Number

Usual Residence of Decedent

Physician

/Medical

Examiner

Funeral

Director

al', or items 23a or 28a-f show the interpretation citized at

Director

Funeral

1. Decedent's Name (First, Middle, Last)

Frank S. Hardy

4a. Facility Name (If not institution, give street and number)

10b. County

4118 Webster Road

Harford

VA MARYLAND HEALTH CARE SYSTEM

6. Sex

1 ₹ M 2 □ F

ICIAN: HARD) 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deat Departiment of Health and Mental Hygiens. In the 18 in the 18		11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 15. Decedent's E	12. Was Decedent Ever in U.S Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 4 2 - 4	1□ Vas 2			14. Race - Am Black, Whi Specify: Wh	ite, etc.
CIAN 21215	within 72 ene. than "ne	Completed	(Specify only highest grades) Elementary/Secondary (0-12) 12	ade completed) College (1-4or 5+) 4	(Give kind of work life, DO NOT use	done during most of working retired)	1		,
TO PHYSI	l be filed ntal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Last)	accountan	18. Mother's Name (,	1
2 E	should nd Men marke imarlc	ပ	John Ernest Hard 19a. Informant's Name/Relationship	,	10h Mailing Address	Margaret Street and Number or Rural			Zin Co do l
Bar Mar	and 2 sho salth and n 27 is m		Pamela Hardy-Cy			er Road Havre			L078
ME KNOWN Baltimore,	Pages 1 and 3 nent of Health ant: If item 27 ary or other tr		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	20b. Pla ⊒Removal from State	ace of Disposition (Nam metery, crematory or oth	e of Da		. Location - City or	
NAME Balt	permit. Pag Department Important: any injury o		21. Signature of Euneral Sovice Lice Ronald S	nsee Director	22. Name and State A Baltimo	Address of Facility natomy Board re, MD 21201	655 W. Ba	altimore	Street
2	Physician		23a Part1. Enter the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition	plications that caused the death one cause on each line. a PROSTATE CAI		of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Deat UNKNOWN
٦	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):				OIVICIOWIV
60,	be executed ician and burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ					
Division of Vital Records, P.O. Box 68760,	the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death. the secution of the Funeral Director: After this certificate has been signed by the attending physician and apletely filled in by the funeral director, page 2 should be detached for use as the burral-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 □Ectopic pre			23d. Date of de Month	livery Day Year
rds, P.	w requires that the standard of the standard by should be detaction.	ed by Ph	Part II. Dther significant conditions		tting in the underlying ca	use given in Part I.	23e. Did tobacc		o the cause of death
l Reco	The law requate has been page 2 should	Complet					24a. Was an autopsy performed 1 Yes 2 📆	? prior to death?	utopsy findings avai completion of cause s 2 \(\subseteq \text{No} \)
/ita	ician: Th	Be (25. Was case referred to medical examiner?			26. Place of Death (
Ę	hysi his c	၉	1 ☐ Yes 2 🖔 No		R/Outpatient 3 DO/		5 Residence	6 □Other (Spe	ecify)
sion o	ending Physeath. or: After this he funeral di	atlon:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of 28 Injury M	c. Injury at Work? 1 Yes 2 No	d. Describe how in	njury occurred	
Divis	o the Hospital or Attending Physician: The white 24 hours after death. o the Funeral Director: After this certificate hompletely filled in by the funeral director, page	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined		me, farm, street, factory,	office 28	f. Location (Street City or Town, St	and Number or R ate)	ural Route Number,
	the Hospital nin 24 hours the Funeral npletely filled	Medical	29a. Certifier 1	hysician: To the best of my know miner: On the basis of examinati and manner stated.	riedge, death occurred a on and/or investigation,	t the time, date and place, and my opinion, death occurred	d due to the cause at the time, date a	e(s) and manner a and place, and due	s stated. e to the cause(s)
	ro the vithin ro the complex	ž	29b. Signature and title of certifier	D	29c.	License number	29d. i	Date signed (Moni	th, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3. Time of Death Year 2006 9:50P 4c. County of Death CECIL Birthplace (State or Foreign Country) Massachusetts 10d. Inside City Limits 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business/Industry financial le, Maiden Surname) <u>e Brittain</u> ber, City or Town, State, Zip Code) 21078 20c. Location - City or Town, State . Baltimore Street Approximate Interval Between Onset and Death UNKNOWN 23d. Date of delivery Day Month tobacco use contribute to the cause of death?]Yes 2□No 3□Probably 4綦Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes sidence 6 Other (Specify)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

SURESH SHANDELYA, M.D.

IAN 1 0 2006

D57239

VA MARYLAND HEALTH CARE SYSTEM

State of Maryland / Department of Health and Mental Hygiene,

Certificate of Death

7. Age (In yrs. last birthday)

Yrs.

Havre de Grace

10f. Zip Code

21078

10c. City, Town or Location

87

4b. City, Town, or Location of Death

PERRY POINT If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Reg. No.

2. Date of Death Month

JANUARY 4,

8. Date of Birth (Month, Day, Year)

Oct 23, 1918

USA

PERRY POINT, MD

21902

JANUARY 4, 2006

	•	1 - For State Registrar	Otate of Wit	•	epartment of Health Certificate of Death		Reg. No	-000	00276
	<i>\$</i> *	1. Decedent's Name (First, Middle,	Last)			2.	Date of Death Month Da	y_ Year	3. Time of Death
rysicia Medic		JAMES	E.		HOWARD		musey	3 2006	9:04P
xamin		4a. Facility Name (If not institution, SINAL (105PI)		TIMOR	4b. City, Town, or Location BALTIMORE		40.	. County of Death	NIA
neral ector		5. Social Security Number 230 - 30 - 538 7	5. Sex 120 M 2□ F	e (In yrs. last birti	day) If Under 1 Year If Under 1 Year If Under 1. Hours rs.	Min. A	Date of Birth (Month, Day, Year) PRIL 2/,1	(101 11)	nplace (State or Foreigntry)
		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limit
a La	ŏ	MADINAIN	11/8		Bana	-, un	RE CI	T1/	1 XYes 2□N
netit	Funeral Director	10e. Street and Number	70 / 71		10f. Zip Code	7770		tizen of What Cou	untry?
1 Pe	<u>e</u>	5432 NA	RC155US	5 AVEN	WE 21	215	•	USA	L.
L	ner	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent of Hispanic O	rigin? (Specify	y Yes or No-	14. Race - Amer Black, White	
College	正	1 ☐ Never Married 200 Marrie	d 1 ☐ Yes 2 📈 i	No	1 ☐ Yes 2 No Specify		un, 0.0.,	Specify:	, 610.
Ex	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:				(/	100	ACK
adle	Be Completed	15. Decedent's (Specify only highest		16a.	Decedent's Usual Occupation 'Give kind of work done during mo life. DO NOT use retired)	st of working	16b. K	(ind of Business/I	ndustry
N 90	g E	Elementary/Secondary (0-12) 3 RD G R AD E	Coltege (1-4or 5	5+)	11	SORTE	E0 /11	LIFEN TO	RON & META
aut, ii	ပို	17. Father's Name (First, Middle, Li	ast)				irst, Middle, Maiden		UN TITELL
X	To B	TOHA		HOWA	en Fi	17 AV	2574	STEVE	=N50N
ımat	-	19a. Informant's Name/Relationshi	p (Type, Print)		Mailing Address (Street and Numi	ber or Rural R	oute Number, City of	or Town, State, Z	ip Code)
rtra		LAWRENCE L	VTE (50.	N) 5	432 NARCIS	5505	AVE BA	170. HI	2121
othe		20a. Method of Disposition		20b. Place of	Disposition (Name of crematory or other place)	Date		ocation - City or 1	
0		1 Burial 2 Cremation	B Removal from State		, cromatory or outer piace)				
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injur.	ļ	4 ☐ Donation 5 ☐ Other (Special Service Li		METR	22. Name and Ad ss of Fac		1-06 BA	FUNE	MARYLI PAJ HOJ
eny injury or other traumatic event, the Modical Exercises must be notified at once.				METR	22 Name and Advise of Faci		-06 BA OWN JR AVE BI	FUNE ALTO, M	RAL HOI
eny injury		21. Signature of Funeral Service Li	L. W.	Maine	22. Name and Adv ss of Fac	ILTON	-06 BA OWN TR AVE . BI aspiratory frest,	FUNE ALTO, M	MAKYLA RAL HOI D. 2 12 Approximate Interval Between
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State Registrar

DHMH 17 Rev 1/2001

SINA HOSPITAL

OF BAITIMALE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOTE HAWA PUROUT W.B.B. S

31. Date filed (Month, Day, Year)

JAN 1 0 2005

			For State Registrar	State of Maryland		artment of H			_	giene	06	00271
			Decedent's Name (First, Middle, Las	t)					2. Date of De	ath		3. Time of Death
	Physici		BABY BOY HO	IDGINS					JANUAR'	Day 3	ZOC6	9:54 AM
	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location	of Death			nty of Death	1
			GREATER BALTIMOR	LE MEDICAL CEN	TER	TOWSON	J			BA	LTIMO	RE'
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la		If Under 1 Year Months Days	If Under		8. Date of Bir (Month, Da	th Vear	9. Birthp	place (State or Foreign
	Director		NONE 1	X M 2□F	Yrs.	Months Days	Hours	51	01-03		000	my MD
	P.		Usual Residence of Decedent									0d. Inside City Limits
	how	<u>.</u>	10a. State 10b. County		Town or Lo		T11					1 es 2 No
	Ba-f	cto	MD BALTIMU	BA.	L/ //90	ORE CI	14					
	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f ehow ant, the Modical Examiner must be notified at	Funeral Director	3918 PRINCE	Ly WAY		10f. Zip Code	212	08		10g. Citizen o	of What Cour	ntry?
•	dea	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. \	Was Decedent of H	lispanic Or an, Mexica	igin? (Spe n, Puerto	cify Yes or No Rican, etc.)	- 14. P	ace - Americ lack, White,	
ဖွ	or it	/Fu	1 Never Married 2 Married	1 □Yes 2 No	ĺ	Yes 2 No	Specify:		. ,		ity: BL	. 1
21215-0036	irai'.	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:								•
5	72 hour natural	Completed	15. Decedent's Ed (Specify only highest gra-		(Give	lent's Usual Occup kind of work done	during mos	st of worki	ng	16b. Kind of	Business/Inc	dustry
7	han n	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	1170. 1	DO NOT use retired	PAN	7		TN)	FAN	/
	be filed withir ital Hygiene. Id other than		17. Father's Name (First, Middle, Last)	0		2111	10 Moth	ode Name	(First, Middle	Maidan Sum	amal	
٦	d ta b	Be	17. Father's Name (First, Middle, Last)	PENCER			18. MOLIT	A/A		GING		
Maryland	s 1 and 2 should be filed within t Health and Mental Hygiene flem 27 is marked other than other traumatic event, the M	ျှ	Dungine		405 44-15		///	<i>V/</i> /				Codel
Mar	2 sh and is m		19a. Informant's Name/Relationship (7	ype, Print)	6 Or	g Address (Street	1 1	n /	T HOUTE INUMB	Ton. 16	m, State, Zip	2124/6
			ODITIC THIRDEOD	20h Pla	ace of Dispo	sition (Name of	MANO	45) (.	20c Locatio	n - City or To	Wn State
or o	(h) () h		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	metery, cren	natory or other place	ce)			200. 2002110	in-City of 10	AAD
altimore	men tant: jury		4 □ Donation 5 □ Other (Specify		een	MOUN		1 05	1	MATTER	well,	MU
Ball	permit. Pages Depertment of Important: If if any injury or o		21. Signature of Funeral Service Licen	_	22	Name and Addre	ss of Facili	MING	YRYW-	JUNFING	of Son	15 CO-
	0.0.5 a o		V - U.	ALO	16	924 10	old	14.	MONE	ton,	40	21111
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death. One cause on each line.	. Do not ent	er the mode of difin	ng, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a EXTERNE	Pa=	MATURI	TU					
7	/Medical Examiner		resulting in death)	a. Due to (or as a consequ	ence of):		1					
	CXAIIIIIei		Sequentially list conditions,	D. PRENATURE	RU	TURE OF	F M	SUB	RANES	5		
	P ==	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence ot):							
	cate be executed bhysicien and the burial-transit	cam	that initiated events resulting in death) Last	C. Due to (os as a conseque	ones of):							
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8760,	ate b	lica	•	d								
9	eath certific attending pl	Physician/Medical	IF FEMALE:	23c. If yes, outcome of pregnan	.01					-		
Box	ath c	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy	/				Date of delive Month	ory Day Year
	the a	sic	1 Yes 2 No	4□Pregnant at time of de 9□Unknown	atn 5∟	Other (specify)						
P.0	that the de ned by the a detached t	Phy	Part II. Other significant conditions or	antichuting to death but not resul	ting in the u	aderlying cause gry	en in Part		23a Did t	obacco use co	ntribute to th	ne cause of death?
Ś	res tha signed be del	by	Partin Other signmount conditions of	Sittle of the stat	ang in the di	idony ing daddo giv	on my art		10	1-		ably 4 Unknown
9	w require been si should I	Completed										
ec	law 185 b	npie							24a. Was autoj		prior to cor death?	psy findings available mpletion of cause of
- E	The page	Col							1 Yes	212 No	1 Yes	2 🗌 No
/ita	ding Physician: The law h. After this certificate hes t funeral director, page 2 s	Be	25. Was case referred to medical examiner?			Tai		e of Death	(Check only o	nne)		
_	Physic this c	P P	1 ☐ Yes 2 No		R/Outpatien		4 🗆 191		me 5 Resi			y)
_	Ing P	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	Wor			28d. Describe	now injury occ	urrea	
Si Si	death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2		201 1 1 /	24		/ Co. to March
Division of Vital Records,	l or Attending I after death. Director: After in by the funer	Certification;	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, str	eet, factory, office		2	28f. Location (i City or To		nber or Hura	ll Route Number,
	urs a											
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical Exam	ysician: To the best of my know niner: On the basis of examinati								
	the land 2 the mplet	Med	29b. Signature and title of celtifier	and manner stated.	_	29c. Licens	e number			29d. Date sid	ned (Moth	Day Year)
	To To		250. Signatural and title of certiner			100 LICENS	7 (3)	1		1	3/2	6
			P	most.	w	1 1000	150	2				_
			30. Name and address of person who	completed cause of death (Item	23а) (Турв	Print) R	1		RVILL	1- K	カクノ	092
			31. Date filed (Month, Day, Year)	32. Regularar's Signatu	2/A	45/)1	3. L	UJHE	TVIL	5///	VAI	
	Sta Registi		4	2006 Segue	K	Secreti)						
	riegist	-41	OTHER D	TOOM MANAGEMENT	100							

			For State Registrar		State o	f Marylar		artment o		alth and M eath		giene	06	002	72
	Physici	an	1. Decedent's Name		. 1	e c		<u>-</u>			2. Date of Dea Month	Day	Year	3. Time of 3'.15	f Death
	/Media		4a. Facility Name (II		Ne street and nur			4b. City, Tov	wn, or Lo	ocation of Death	January		JOO C	7.13	Р™
		1. 高度	Baltimor			Medie	of Cent	er GI	ev.	Burnie			ne A	rund	e \
	Funeral Director		5. Social Security N 188–20–57		Sex 12≦M 2☐F	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Y Months D		f Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 6-29-	h v, <i>Year)</i> -1927	Year) 9. Birthplace (State or Foreigr Country) PA		
-	D		Usual Residence of	Decedent			ty, Town or Lo					1,2,			Sec. 2.5. 14
	Maryla f show	ō	10a. State MD	10b. County Anne Ar	unde1		len Bu							10d. Inside Ci 1 ☐ Yes	ty Limits 2 ☑ No
	deeth with the Maryland ma 23a or 28a-f show millet be notified at	Director	10e. Street and Nur		unuu I		Ten bu	10f. Zip Co	ode			10g. Citizen	of What Cou	ntry?	
	th with	ai D	1701 Tiem	an Drive				210	061			U.S	.A.		
	ar dee	Funerai	11. Marital Status	27.	Armed Fo	edent Ever in U prces?	.S. 13. \	Was Decedent f Yes, specify	t of Hisp Cuban,	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.1	Race - Americ Black, White,		
90	urs afte	by F	1 Never Marri	ied 2. Married 4. Divorced	1 ZYes If Yes, Giv Year or D	VΘ		l⊡Yes 2√⊡	X No	Specify:		Spe	ecify: Wh	ite	
č	72 hor	eted	(Spec	15. Decedent's E	ducation ade completed)		(Give	lent's Usual O	done dur	on ing most of worki	ina	16b. Kind o	f Business/In	dustry	
Č	within sne.	Completed	Elementary/Secon		College (1	1-4or 5+)	life. I	oo NOT use r Vorker	retired)			Gana	ral Mo	tore	
7	filed Hygie other	Be Co	17. Father's Name ((First, Middle, Las	t)		Auto	VOIKEI	11	B. Mother's Name	(First, Middle,			LUIS	
	Vid be Wental	To B	Roy Dewe	y Hughes						Florenc	e Mae S	nyder			
	2 sho		19a. Informant's Na							Number or Rura				Code)	
-	DESILITION CE, MISTY JETTO ZIZIO-0030 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Deperment of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Itema 23a or 28a-f show any injury or other traumatic event, the Madical Examination masks invitiled at ance.		Mrs. Ann Shirley Hughes /wife 1701 Tieman Drive; Glen Burrie, MD 21061 20b. Place of Disposition (Name of Disposition Olare Date 20c. Location - City or Town, State												
	Pages ent of nt: If II			Cremation 3 [5 □ Other (Speci		State	emetery, cren esapeal	•		on 1-7-	2006	Steve	ensvil	la MTD	
1	mit. ppertm spertm ports y Inju		21. Signature of Fu			/	22	. Name and A	Address	of Facility Sin	gleton	Funera	al Home	e, PA	
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			shock, or heal	rt failure. List only	one cause on e	ach line.	L	1	1		1	rest,		Approximat Interval Bet Onset and I	ween Death
	Physician /Medical		disease or conditio resulting in death)		a	or as a conseq	<u> </u>	भ्रम् व	15/17-	ess syr	idrome			d wee	KC
And I	Examiner		Seguentially list cor	nditions.	b										
2	led sit	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	mediate rlying injury	Due to	(or as a conseq	uence of):								
2	execut n and ial-trar	Exan	that initiated events resulting in death) L		c. Due to	(or as a conseq	uence of):								
200	cate be executed physician and the burial-transit			- (d										
23	Certificate Iding phys	Med	IF FEMALE:		00-14									***	
	death c	Physician/Medical	23b. Was decedent in the past 12 1 \(\sum \text{Yes} \) 2 \(\sum \text{Ves} \)	months?	1 Live b	tcome of pregna pirth 2 Feta tant at time of d	Ideath 3	Ectopic pregn				23d.	Date of delive Month	*	Year
3	hat the d by the detached	hysi	9 ☐ Unknown		9□ Unkn	own									
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	been should	eted	Paul	y gorlic		sm ref	MIT CI	دراهم ار)			es 2□No		ably 4 🚁	
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		BeC	25. Was case reference examiner?	red to medical					2	6. Place of Death		2 No No	1 🗆 Yes	ZIZ NO	
2	hyeic hyeic this ce	မ	1 ☐ Yes 242		-		ER/Outpatien			4 Nursing Ho				y)	
	ding fine.	tion	27. Manner of Death 1 ■Natural 2 □ Accident	n 5 ☐ Pending investigatio		of Injury th, Day Year)	28b. Time of Injury	28c.	linjury at Work? 1 ☐ Yes	s 2□No	28d. Describe h	ow injury oc	curred		
	INVISION OF VICEN DECOLOS, for Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not to determined	be 28e. Place	of Injury - At h	ome, farm, str	eet, factory, of	ffice		28f. Location (S City or Tow	treet and Nu	mber or Rura	il Route Num	ber.
č	itelor rate or rate Dir		- Little and a second												
	LIVISIOII OF VICEI THE WITHING TO THE INC. TO THE HOSPITED OF ALTER OF THE MAINING THE PROPERTY TO THE FUNDER DIRECTOR. After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one)	1 € Certifying P 2 ☐ Medical Exa	miner: On the b	best of my kno asis of examina ner stated.	owledge, death ution and/or inv	occurred at the estigation, in	the time, my opin	date and place, a ion, death occurr	and due to the d ed at the time, o	ause(s) and late and plac	manner as si ce, and due to	tated. the cause(s	.)
	To the within To the complement	Me	29b. Signature and	title of certifier	1				icense n		4	1	ned (Month,		
	1		> \(\(\)	, went	fanos	2 mb		D	002	2483		Janua	vy 3,	2006	
	/		30. Name and address	T JACO	as my	se of death (Iter	n 23a) (Typp,	Print)	r. (2483 Slem Bu	rnie, M	no a	vy 3,		
	Sta Registi		31. Date filed (Mon	th, Day, Year) N 1 0 200		legistrar's Signa	ature des	SE)							

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 2006 8:15 pmm January Evelyn Margaret Harold /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Berlin Nursing and Rehabilitation Ctr. Worcester Berlin 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2X F 2-16-1933 Director 213-30-1302 VA Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County itam 27 is marked other than "neturel", or items 23a or 28e-1 show other traumatic event, the Mudical Examinations by multipled at 1 ☐ Yes 2 No Berlin MD Worcester Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20 Offshore Lane 21811 U.S.A. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married ☐Yes 2000No Harold, Evelyn altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Mental Hygiene. arked other than Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Accounting 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dewey F. Branham Margaret Duff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If itam 27 Is any injury or other traisons. Mr. William Harold / Husband 20 Offshore Lane; Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Pk 1-9-2006 Elkridge, MD 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 MOHJO 236. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or property line. Approximate Interval Between Onset and Death Immediate Cause (Final arkingen Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Insuacor right] that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law raquires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Dav 5 Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed baen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1□ Yes To the Hospitel or Attending Physicien: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Sursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Yes 2 No 3□ DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending after death. investigation 1 Tyes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 106 who completed cause of death (Item 23a) (Type, Print) portel thing Fewet Folder De 19944 Melidas Isodules -5 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician January Pay. 2013/4 8:13 FM Clara Marie Inners /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 23 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Director 215-17-1701 91 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√□ No Director Maryland Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 7903 Hilltop Avenue by Funeral 21236 U.S.A. "naturel", or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married ☐ Yes 2X☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 🏌 ☐ No Specify: 3 Widowed 4 Divorced Specify: ear or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Martins Airport permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if tiem 27 is marked othh eny lipluy or other traumatic event ARRs. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Chojnacki Pelagia Wasowicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin W. Inners (Husband 7903 Hilltop Avenue Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 13 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2006 Timonium, Maryland 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem. 21. Signature of Fun and Service Literate ²², Name and Address of Facility W. Dabrowski/Chojnacki Funeral Homes P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Dan't. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction Days /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months? Month Year 4 Pregnant at time of death Day 5 Other (specify) 9 Unknown 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been si should 2 No 3 ☐ Probably 4 ☐Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes ineral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. a er of Deat

1 atural
2 Accident Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 Pendino Injury I Director: A death М investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Thomicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D ØØ17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Abdallah J.</u> Helou, M. D. 7601 Osler Drive Towson, Maryland 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

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			For State Registrar	of Maryland / Depar <i>Certi</i>	tment of Hea ficate of De	ath	giene 006	00275
B	Physici	an	Decedent's Name (First, Middle, Last)	4 CK SON		2. Date of Dea Month	ath Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and n	umber)	Nb. City, Town, or Loc RAWDAU	ation of Death	4c. County of Deat	
	Funeral		NONTOWCST HO J 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If	Under 24 Hrs. 8. Date of Birt ours Min. (Month, Da	th 9. Birth	nplace (State or Foreign untry)
	Director		212.44. 9623 1□ M 280 F Usual Residence of Decedent	59 Yrs.	John Sayo	04.16.	1946	MD
	f ehow	ō	MD BALTIMORE	10c. City, Town or Loca				10d. Inside City Limits 1 ☐ Yes 2 No
	or 28a-	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	untry?
	ms 23a	Funeral		cedent Ever in U.S. 13. Wa	21228 is Decedent of Hispa	nic Origin? (Specify Yes or No	14. Race - Ame	
980	d within 72 hours after deeth with the Maryland jiene. r then "naturel", or items 23a or 28a-f ehow the Madical Examinat must be nuiffied at	Ď	1 □ Never Married 2 ☑ Married 1 □ Yes, 1 Yes, 2 Year or	2 5 4No Give 1D		lexican, Puerto Rican, etc.)	Specify: BU	etc. ACK
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212	il Hygiene. other then "	Com	10 TH GRADE N	(1-4or 5+) A CO	-		FOOD SERV	ICE
land	id be ental ked c	To Be	17. Father's Name (First, Middle, Last) MILTON MOORE			Mother's Name (First, Middle, DROTHY JORDAN		
Maryland 21215-0036	nd 2 shullth end 27 ie m		19a. Informant's Name/Relationship (Type, Print) FRANKLIN JACKSON (HU		Address (Street and a	Number or Rural Route Number ROAD CATON	er, City or Town, State, 2 SVILLE MI	01-00
lore	Pages 1 el nent of Hea int: if item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	n State ,	ion (Name of tory or other place)	Date	20c. Location - City or	
Baltimore,	permit. Pages 1 Depertment of H Important: if ite eny injury or ott		4 Donation 5 Other (Specify) 21. Sign ure of Funeral Service License	KING PARK	Name and Address of	01.10.06 Facility Fuyerat	RANDAUSTON SERVICE	UN , MD
	20529		23a. Part1. Enter the disease, or complications that	t caused the death. Do not enter	BALTO, NA	TO PIKE, BALTO.	MD 21229	Approximate
	Physician		shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	each line. SEF	'SIS			Interval Between Onset and Death
	/Medical Examiner		Due t	o (or as a consequence of):				
	rted	Examiner	if any, leading to immediate Due to cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):		- 1		
60,	icate be executed physicien and s the burial-transit		that initiated events	o (or as a consequence of):				
(68760)	ertificate ing physi e as the	Medical	IF FEMALE:	4 250 27 - 300 227				
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<u>a</u>	es that th igned by be detac	by Ph	Part II. Other significant conditions contributing to	death but not resulting in the und	erlying cause given in	Part I. 23e. Did to	obacco use contribute to	the cause of death?
cord	v require been sign	eted	CHILONIC RENA	T 741L	UICE	1 🗆 \		obably 4 Unknown topsy findings available
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Vita	Physicien: Th this certificete ral director, pag	To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 115	Inpatient 2 ER/Outpatient	Other	. Place of Death (Check only o		n(v)
n of	ding Phy h. After this funeral c		27. Manner of Death 1 Natural 5 Pending (Mo	e of Injury 28b. Time of Injury	28c. Injury at Work?	28d. Describe h	now injury occurred	
Division	or Attendifier deati	Certification:		ce of Injury - At home, farm, stree ding, etc. (Specify)		2 No 28f. Location (S	Street and Number or Ru vn, State)	ral Route Number,
_	To the Hospitet or At within 24 hours efter of To the Funerel Direct completely filled in by	Medical Co	(Check only 2 Medical Examiner: On the	he best of my knowledge, death of basis of examination and/or inve				
	To th withir To th comp	Me	29b. Signature and title of certifier	in les	29c. License nu		29d. Date signed (Monti	
	3		30. Name and address of person who completed ca	use of death (Item 23a) (Type, Pr	int) SA	LTO. MP	21133	
	Sta Regista			Registrar's Signature				
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п	Physicia			yn Bradl	ov Inak	con		Month	8, 2006	4:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give		ey Jack		or Location of Dea		4c. County of Deati	
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	Funeral		5. Social Security Number 6. Se	7. Ag	e (In yrs. last birthda		If Under 24 Hrs			nplace (State or Foreign untry)
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	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
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	or death with the Marylan tems 23a or 28e-f show or must be notified at	Directo	Maryland Balti 10e. Street and Number	поге		10f. Zip Code	uxton	100	g. Citizen of What Co	untry?
	3a or		303 North Wind	Road			21204		USA	,
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 1	Was Decedent of If Yes, specify Cub		Specify Yes or No-	14. Race - Ame	
٥	after or ite	T.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀! If Yes, Give	No	1 ☐ Yes 2X No		no rican, etc.)	Black, White	9, etc.
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<u>a</u>		To B	James Edwin B	adlev			Kathr	yn Gassawa	y Gambril	1
Maryland 2	2 should have and have trained to the man		19a. Informant's Name/Relationship (7	ype, Print)	19b. M	ailing Address (Stree		ural Route Number, (
	s 1 and 2 should f Health and Mer itsm 27 is marke other treumatic		Patricia Jackson C	enkins/Da		03 North	Wind Road	d Ruxton.		
ore	0° = 5		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐	Removal from State	20b. Place of Discemetery, of	sposition (Name of crematory or other pla	ace)	Date 20	oc. Location - City or	Town, State
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Ba	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licen			22. Name and Addr				of MD, Inc.
			Edward A. org	gorchik	the death. Do not	299 Frede			ore, MD 21	.228 Approximate
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each li	ne.	1.1.0	1 1-11	verslat/		Interval Between Onset and Death
À	Physician /Medical		disease or condition resulting in death)	a. Due to for as	a consequence of):	delia	dy me	0-1-7011 4		Buron
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8760	physic the t	dicai	•	d	y prog	- Win				1
Box	eath certific ettending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of deli	verv
ň	death cen e ettendin d for use	iciai	in the past 12 months?	4 Pregnant at		3 □Ectopic pregnand 5 □ Other (specify) _	у		Month	Day Year
0.	t the by the tache	hys	9 □ Unknown	9□ Unknown						
	The law requires that the death certific te hes been signed by the ettending p age 2 should be detached for use as	by P	Part II. Other significant conditions co	ntributing to death b	out not resulting in th	e underlying cause g	ven in Part I.	23e. Did toba	cco use contribute to	
ord	w require been signature	ted						1 🗆 Yes	2 No 3 Pro	obably 4 Unknown
Division of Vital Records,	elawi hesb	Completed			,			24a. Was an autopsy	prior to d	topsy findings available completion of cause of
E H	: The	Co						performe 1 ☐ Yes 2		2 No
<u> </u>	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		0:	han 1	eath (Check only one)		
ō	Phys r this ral di	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 U Inpatie		tient 3 DOA	4 Nursing	Home 5 ☐ Residen 28d. Describe how		orly)
lo	th. : Afte	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	uý Year) Inju		ork?]Yes 2∐No			
NIS.	Attendar dea	ifice	3 Suicide 6 Could not be determined	286. Place of In	jury - At home, farm,	street, factory, office		28f. Location (Stre City or Town,	et and Number or Ru	ral Route Number,
ō	ital or rs afte et Dir	Certification:	- I Tomordo	Бияйніў, Өг	tc. (Specify)			Say or rown,	310/	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funarel Director: After this certificate he completely filled in by the funeral director, page	edicai	(Check only 2 Medical Exam	iner: On the basis o	f examination and/o	eath occurred at the t	ime, date and place opinion, death occ	e, and due to the cau	se(s) and manner as e and place, and due	stated. to the cause(s)
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner st	ated.		se number		d. Date signed (Monti	
	£ ₹ 8		VOIAM.	M.L.	und	/)		J,		
,	5		30. Name and address of person why	completed care of	death (Item 23a) (Tu	oe. Printi				(
	J		MARiley G	Ante 6	701 N.a.	unles St. 1.	Balto. 1	111 202	20/6	
4.9	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	.0				
	Registr	rar	JAN 1 0 2006	Alamo -	M. Con	2808				

			1 - For State Registrar	State of	Maryland		rtment o		and Menta h	al Hygie _{Reg.}	200	6 0	0277
	Physic	cian	Decedent's Name (First, Middle, Last							te of Death	Day C	Year	3. Time of Death
	/Med	lical	John F. J 4a. Facility Name (If not institution, give				4b. City, Tow	n or Location	n of Death	/	4c. County	OG of Death	1930pm
	Exam	iner	Upper Chesapea				•	Air		I	HArfo		
	Funera	1	Social Security Number 6. S.		. Age (In yrs. la		If Under 1 Ye		er 24 Hrs. 8. Da	te of Birth	ear)	9. Birthpla	ace (State or Foreign
	Directo	r	Usual Residence of Decedent	X M 2□ F	93	Yrs.		,	May	onth, Day, Ye	1912	MAr	land
	land wo		10a. State 10b. County		10c. City	, Town or Loc	cation					10	d. Inside City Limits
	a-feh	ctor	MD Balti	more		Esse	X						1 ☐ Yes 2 ☐ No
	ath with the Marylar 23a or 28a-1 ehow	Director	10e. Street and Number				10f. Zip Cod				Citizen of W	hat Count	ry?
	eath v	Funerai	515 Mace Ave	12. Was Decede	ent Ever in U.S	3 13 W		1221	Origin? (Specify Ye		JSA 14. Bace	- America	n Indian.
	1215-0036 within 72 hours after death with the Maryland ane. than "natural; or items 23e or 28e-1 ehow he Madical Examiner must be notitified at		1 Never Married 2 Married	Armed Force 1 ☐ Yes 2	es?	If			Origin? (Specify Ye can, Puerto Rican, ,	etc.)	Blac	k, White, e	tc.
\subseteq	5-0036 72 hours aff	d by	3€ Widowed 4 Divorced	If Yes, Give Year or Date	es:	1	☐ Yes 25x	No Specif	ty:		Specify	Whi	te
9	15-003 n 72 hours "natural", adical Ex	lete	15. Decedent's Ed (Specify only highest gra			16a. Decede (Give k	ent's Usual Oc and of work do	cupation one during me tired)	ost of working		. Kind of Bu		,
0	d 212 filed within Hygiene. other them	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)	Weld		.,, 00,		F	Reams	Manu:	factor
1930 PM	be filed that Hygie of other event, II	BeC	17. Father's Name (First, Middle, Last)					18. Mot	ther's Name (First,	Middle, Mai	den Sumam	θ)	
	Aarylanc 2 should be f and Mental H is marked of	10	Benedict Jac						nna Tok				
0	Maryland 2121 nd 2 should be filed within lith and Mental Hygiene. 271s marked other than "	10	19a. Informant's Name/Relationship (า	1			Court F				
90/8			20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Pl	ace of Dispos	sition (Name o	f I	Date		. Location -		
8	altimore, mit. Pages 1 a spertment of Hei portant: if item		1 B Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		ate Ho	lyRos	aryCe	meter	y 1/12/	06	Balt	imor	e MD
_	Baltimo		21. Signature of Funeral Service Licen	(On sale	Oly	22.	Name and Ad		Conne				eofEssex
			23a. Part1. Enter the disease, or corp shock, or heart failure. List only	ofications that cau	used the doubt	. Do not ente							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, Iso	honu	ca	letin						Onset and Death
.0	/Medica Examine		resulting in death)	Due to (or	r as a consequ	ence of):							2 dain
1	* *	e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequ	ince of).	e_					-	
\$	760, be executed sician and burial-transit	Examiner	that initiated events	c									
ま	8760, ate be executed hysician and the burial-transit	EX	resulting in death) Last	Due to (or	r as a consequ	ence of):							
\mathcal{Z}	hy at	dica		d									
#	X Centific centific ding	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco							23d. Date	e of deliver	y
	. 0 60	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		th 2 Fetal nt at time of de		Ectopic pregna Other (specify				Mor	nth E	Day Year
5	P.C nat the d by the	Phy	9 Unknown Part II. Other significant conditions of			Iting in the un	alaukiaa aa	ower in Dec	41 22	Ra. Dud tahaa	20 upo contr	abuta ta tha	cause of death?
10	Records, P.O. The law requires that the law seen signed by this page 2 should be detached.	d by	PARTICULAR SIGNIFICANT CONTROLLS	0 0 0 / C	Dimonion	COLIA.	CEV (15.10 C)	1 ☐ Yes	/		bly 4 Unknown
1	cord w requir been si	lete	2.71	~ ()		0000		10101	24	la. Was an	24b. V	Vere autop:	sy findings available
Ÿ	of Vital Record Physician: The law requir this certificate has been s ral director, page 2 should	Completed by								autopsy performed Yes 2	1?	rior to com leath?	sy findings available pletion of cause of
5		BeC	25. Was case referred to medical examiner?				***************************************	26. Pla	ace of Death Chec			103	
5	of Vital Physician: this certific	2	1 Yes 2 No			ER/Outpatient			Nursing Home 5				
achimski		tion;	27. Manner of Death 1 Anatural 5 Pending 2 Accident Investigation	28a. Date of (Month,		28b. Time of Injury		njury at Work? 1 ☐ Yes 2 (escribe how i	nlury occurr	ed	
B	Division Tor Attending after death. Director: After in by the funer	ifica	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	100	of Injury - At hos g, etc. (Specify	me, farm, stre			28f. Lo	cation (Stree	t and Numbe	er or Rurai	Route Number,
Ja	Div	Certification:	4 Homicide	building	з, етс. (<i>Specify</i>)			Cit	ty or Town, S	tate)		
1/	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier 1 Tertifying Ph (Check only one) 2 Medical Exam	ywrian: To the b niner: On the bas and manne	is of examinat	wladge, death ion and/or inv	occurred at the restigation, in re-	e time; data ny opinion, d	and place, and di- leath occurred at the	e to the caus he time, date	and place, a	mar as eta and due to t	ted he cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier					ense numbe		29d.	Date signed	(Month, D	ay, Year)
	ix		fren	/n				95363	355		1/9	1200	6
	4		30. Name and address of person who	completed cause	of death (Item	23a) (Type, F	Print)						
	e apolitica S	tate	31. Date filed (Month, Day, Year)	32. B	gistrar's Signat	ture	U.C.						
	Regis	strar	JAN 1 o :	2006	0//	W R	2000						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item#18, pertil (351, 1/30/05) The State of Maryland / Department of Health and Mental Hygiene 2 () () 6 00278 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day_ Month Year **Physician** JANUARY JONES 7 . CL A.M MARGARET 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan HOS pital baltimore 8. Date of Birth OCT. 4, 1937 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Hours 249-58-1268 Months Days 68 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Mudical Examiner must be notified at 1√ Yes 2 No MD Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Items 23a 808 WILBERT AVENUE 21212 Funeral <u>USA</u> filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: BLACK Completed by 3 ₩ Widowed 4 Divorced "nature!", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) other then College (1-4or 5+) BALTIMORE CITY 12 JANITORIAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental ! Eunice Pages 1 end 2 should be timent of Health and Mentatent: if item 27 is marked WILLIE **JAMES** TILLMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OGDEN JONES/SON 2904 VIRGINIA AVENUE, BALTO., MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department o Importent: if any injury or once. MT 01-14-2006 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC melo 1701 LAURENS ST., BALTO., MD 21217 23a. Patr1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASEVO know /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-translt Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ivision of Vital Records, Š 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1º Yes 2 No 2 ER/Outpatient 1 Inpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural Injury 5 Pending To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JAN 1 0 2006

29b. Signature and title of certifier

SHASH strar's Signature 32. Rg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 LOCH RAVEN BOULEVARD, MD

29c. License number

0018230

29d. Date signed (Month, Day, Year)

JANUARY 5,2006

State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item#5 per FH G851 1/17/06rt@cate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O 1 O 5 Day **Physician** JAIL 30 PM JOHNSON 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b_City, Town, or Location of Death 4c. County of Death Examiner 15ACTI MORE HOSPINAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 K Yrs Director 218-60-1526 04/02/1953 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iteme 23a or 28a-f show ner must be notified at 1 Ves 2 No Be Completed by Funeral Director Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21215 U.S.A. 3809 Hayward Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. the Medical Examiner Pages 1 and 2 should be tiled within 72 hours after one of Health and Mental Hygiene.
ant: If item 27 ie marked other then "natural", or ites ary or other traumatic event, the Macical Examined. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mabel Thorne 2 William Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Reazer / Sister 5200 Cuthbert Avenue, baltimore, Maryland 21215 ace of Disposition (Name of Date 20c. Location · City or Town, State 01/12/2006 Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment of important: If eny injury or once. King Memorial ParkCeme. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityThe Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Md. 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DASAL GANGIA MENORRIME **Physician** hRS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 25 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: To the Hospital or Attending 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 ST. PAUL PLACE BACTIMONE NO 21202)05 CPL-OTNA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar

			For State Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death	00280
ž,	Physici	an	Decedent's Name (First, Middle, Last	2. Date of Death Month Day Yes	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give	JONES Street and number) 4b. City, Town, or Location of Death 4c. County of D	06 2:10 M
¥.		Fysik Typik	Stella War 5. Social Security Number 6. Se	15 HOSPICE TIMONIUM Ba 7. Age (Inlyrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9.1	Himore Birthplace (State or Foreign
	Funeral Director		230-42-6233 10	7. Age (Inlyrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. M 201F 75 Yrs. Months Days Hours Min. June 7, 1730 9.	Birthplace (State or Foreign Country)
	ryland	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
	death with the Maryland rms 23a or 28e-t ehow rms 1.be notified at	Funeral Director	Mary and N/	T Salt More 10f. Zip Code 10g. Citizen of What	1 XYes 2 □ No
	23a or	raf Di	3904 Boa	rman Ave. 21215 US	SA
36	should be filed within 72 hours after death with the Marylar ad Mental Hygiene. marked other then "natural", or flems 23a or 28e-1 ehow marked other then "natural", and madical Examinations to notified a	by Fune	11. Marital Status 11 Never Married 2 Married 3 Widowed 4 Divorced		merican Indian, Inite, etc.
15-0036	72 hou	eted	15. Decedent's Edi (Specify only highest grad	cation 16a. Decedent's Usual Occupation 16b. Kind of Busine ocmpleted (Give kind of work done during most of working	iss/industry
2	d within giene. er then	Completed	Elementary/Secondary (0-12)	College (1-40r5+) Day Care Worker Pri	vate
Maryland 2	ould be filed Mental Hygi arked other atic event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)	<u> </u>
ary	2 6 6	P.	19a. Informant's Name/Relationship (T	pe, Print) (daug tes) 19b. Mailing Address Street and Number or Rural Route Number, City or Town, Stat	e, Zip Code)
	s 1 and 2 Health Item 27		IVIS. Khadija 20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	21202 or Town, State
altimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	King Mem. Park 1/10/2006 Bulto.	Md.
Ba	permit. Pag Department Importent: If eny injury o		21. Signature of Funeral Service Licens	Joseph L. Russ Funeral Home,	P.A.
			23a. Party Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final	ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line.	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	aGLIOBLASTOMA Due to (or as a consequence of):	
	Examiner	er	Sequentially list conditions,	b. — Due to (or as a consequence of):	
	and -transit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consequence of):	
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89 xo	eath certifica attending ph I for use as th	/Med	IF FEMALE:	23d Date of	deliver
о. В	The law requires that the death certifit ate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23d. Date of 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month	Day Year
JS, P	uires thal signed t Id be det	þ	Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribut 1 ☐ Yes 2 ☐ No 3 ☐	e to the cause of death? Probably 4 Dunknown
Vital Records,	s been 2 should	Completed		24a. Was an 24b. Were	autopsy findings available
a R	ician: The lav certificate has rector, page 2			performed? death	to completion of cause of 1? ∕es 2□ No
<u> </u>	Physician: The this certificate his all director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check only one) 10 spital: 1	ipecify) HOSPTCE
Division of	ding After funer		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? M 28c. Injury at Work?	
IVIS	or Attending Patter death. Director: After in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)	Rural Route Number,
/	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 17 Certifying Phy (Check only one) Medical Exam	sician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.	as stated. due to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (M	
ĺ	N	,	30. Name and address of person who o	completed cause of death (Item 23a) (Type, Print)	26
	8		DR. TARTO MAHMOOT	2300 DULANEY VALLEY RD. TIMONTUM, MD 21093	
***	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's Signature	
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JANUARY 3,

ETHELINE JONES

				1 - For State Registrar	State of M	arylan		rtment of F		Mental Hygio	ene 0 0 (5 00281	
_		Physici		Decedent's Name (First, Middle, La Regina Mary	Johnson					2. Date of Death Month January	Day Ye 5, 200	3. Time of Death 8:03 a ^M	
		/Medic Examir		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Death		4c. County of E		_
				600 North Hic				Bel			Hari		
		Funeral			Sex 7. Ag 1 □ M 2 🖾 F		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)	1
		Director		213-66-5436 Usual Residence of Decedent		88				June 4,	1917	Maryland	-
		yland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits	
Õ		ith the Marylar or 28a-f show se notified at	cto	Maryland Harf	ord	Bel	Air					Yes 2 □ No	
ohnsor		death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number	7			10f. Zip Code		10	g. Citizen of Wha		
		s 238	erai	600 North Hicko	12. Was Decedent	Ever in II	e 12.1		014	anifu Van ar Na	USZ	A American Indian,	_
0	10	iter de	Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Amed Forces	?	S. 13. Y	Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		White, etc.	
1	5-0036	eal', or	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	□Yes 2√2 No	Specify:		Specify:	White	
	5-0	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	lent's Usual Occup	durina most of work	kina 10	6b. Kind of Busin		_
	121	vithin ne. han	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use retired	1)				
	2	Hygie Hygie ther t		12 17. Father's Name (First, Middle, Lasi	7)		Homem	aker	18. Mother's Nam	e (First, Middle, Ma	Own I		-
	an	d be ental ked o c eve	To Be	Thomas Henry Or					Cecili		Killmar	n	
	Maryland 2121	shou ind M s mar umat	-	19a. Informant's Name/Relationship			19b. Mailin	g Address (Street		ral Route Number,			_
		s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. item 27 is marked other than "natural", or Itams 23a or 28a-f shoy other traumatic event, the Medical Experiment must be notified at		Carol Thacker /	Daughter		192	l Suscinel	anna Hal	1 Bd., Wh	iteford.	ND 21160	
Da	altimore,	of He of He of He of hor oth		20a. Method of Disposition 1 Burial 2 **Cremation 3 **Line 1. **Line 2. **Line 3 **		C	lace of Dispo emetery, cren	sition (Name of natory or other plac	ce)	Date 20	oc. Location - City		
, 2	Ĭ.	Pag Iment tant: I		`4 □Donation 5 □ Other (Speci	fy)	Hi			orp. 1-9			Maryland	
Regina	Ball	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		21. Signatury of Funding Service Lice	ach			Comas Fu 317 Cokes	inerally Horsbury Road	me, P.A. d, Abingd	on, Mary	yland 21009	
(-2				23a. Part1. Enter the disease, or conshock, or heart failure. List on	plications that cause one cause on each I	d the death ine.	n. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	
		Physician		Immediate Cause (Final disease or condition resulting in death)	. ARTE	2018	CLET	ZOTIC	CARDIO	VASCULA	R DISE		
		/Medical Examiner		resolving in dealth)	Due to (or as	a conseq	uence of):						
			er	if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):						
	V	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events									
	0,	be executed sicien and burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):						
	8760	ate be hysicie the bu	icai		d								
	39)	requires that the death certificate een signed by the attending phys nould be detached for use as the	Physician/Medical	IF FEMALE:							1		
	Box 6	ath ca	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Feta	Ideath 3	Ectopic pregnancy	1		23d. Date of Month	f delivery Day Year	
	P.O.	that the death ed by the atte detached for	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	it time or a	eath 5∟	Other (specify) _		-			
	σ.	w requires that the s been signed by the should be detach		Part II. Other significant conditions	contributing to death t	out not res	utting in the ur	nderlying cause grv	en in Part I.	23e. Did toba	cco use contribut	te to the cause of death?	
	rds	quires n sign uid be	ed by	DABETES						1 ☐ Yes	2□No 3□	Probably 4. Unknown	
	00	> 0 0	Completed							24a. Was an	24b. Wer	e autopsy findings available	_
	R	The law ate has b	mo							autopsy performe		r to completion of cause of th? Yes 2 □ No	
	ita	sian: artifica ictor, l	Be	25. Was case referred to medical examiner?	8)					th (Check only one)			_
	of V	hysic this co	은	1 ZYes 2 □ No	Hospital: 1 ☐ Inpati		ER/Outpatien		er: 4 Nursing H		ce 6 □Other (Specify)	_
	on C	ding F	ion:	27. Manuer of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	28c. Injur Wor M 1	y at k? Yes 2 □ No	28d. Describe how	injury occurred		
1	Division of Vital Records,	Attend death ctor: y the	Certification;	2 Accident investigated 3 Suicide 6 Could not 1	De Diana of la	iurv - At ho	ome, farm, str	eet, factory, office	143 2 110	28f. Location (Stre	et and Number o	r Rural Route Number,	_
((4)	ğ	al or / after Dira	erti	4 Homicide	building, e	tc. (Specif	y)	,,		City or Town,	State)		
1)	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	edicai (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner si	of examina	wiedge, death tion and/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and manne e and place, and	r as stated. due to the cause(s)	
		To the To the	Me	29b. Signature and title of certifier	,			29c. Licens				fonth, Day, Year)	_
				> Whhis	ankar 1	MD		Do	15017	JA	NUARY	05, 2006	
		2			completed cause of			Print)	20	, ,,	. 6	05, 2006 14	_
		8		31. Date filed (Month, Day, Year)	YANKAR 32. FORST	rar's Signa		AVENUE	Oth	MRM	12 ×10	14	
		Sta Regist	ate rar		2006 32. ang ist	an s Signa	H A	sales					

E V	VINTON	JU.	RDAN Unpend item#2 1 - State Registrar	State of Mary		artment of artificate o					2006	00282
		m	Decedent's Name (First, Middle, Last)			Timouto o	Dodin		2. Date of De	Reg. No.		3. Time of Death
	Physicia		Duke Winton Jordan						Month JAN.	Day	2006 Year	
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town	or Location of	of Death	JAIV.	1	County of Death	0538 A [™]
	Examin	er	2054 Horseshoe Cir			Jess					ANNE AF	
	Funeral		Social Security Number 6. Sex	7. Age (In	yrs. last birthday	If Under 1 Yea	ar If Under		8. Date of Bir (Month, Da	th		place (State or Foreign intry)
	Director		216-74-0100 地	M 2□F	39 Yrs.	Months Day	rs Hours	Min.	1-16-1	iy, Year) 966	MD	intry)
	D		Usual Residence of Decedent									
	how	_	10a. State 10b. County	100	c. City, Town or L	ocation						10d. Inside City Limits
:	Ba-fa	cto	MD Anne Arur	nde1	Jessup							1 ☐ Yes 2 🛣 No
3	ath with the Marylar 123a or 28a-f show wat be notified at	Funeral Director	10e. Street and Number			10f. Zip Code				10g. Citi	zen of What Cou	untry?
	23a	æ	2054 Horseshoe Circ	le		2079	94			U.	S.A.	
	tame from	Jue		Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent o	f Hispanic Ori uban, Mexicar	gin? (Spen, Puerto	ecify Yes or No Rican, etc.))-	 Race - Amer Black, White 	
9	or if	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐ Yes 22Ω¶No If Yes, Give		1 ☐ Yes 2ŒN					Specify: Whi	te
3	be lied within 72 hours after death with the Maryland tra Hygiene. It have do other than "natural", or itams 23a or 28a-f show event, the Medical Examiner must be notified at	g p		Year or Dates:	1Ca Dani	death Head Oc						
ည်	n 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Giv	edent's Usual Occ e kind of work dor DO NOT use reti	supation ne during mos ired)	t of worki	ing	16b. Kir	nd of Business/I	ndustry
7	then with	m C	Elementary/Secondary (0-12)	College (1-4or 5+)		nstructi					Constr	ruction
ם ס	Hygi Hygi Int,		17. Father's Name (First, Middle, Last)		00	iis ci uc ci		er's Name	(First, Middle	Maiden		decion
		o Be	Robert G. Jordan						M. Lat			
⋝ ∶	mark mati	욘	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mail	ing Address (Stre					Town State Zi	in Code)
<u>8</u>	d 2 s th an th an trau trau		Mr. Julian B. Smith	,						_		p Code)
o o	permit. Pages 1 and 2 should be Deperment of Health and Menta Important: If item 27 is marked sny injury or other treumatic sv 200cg.		20a. Method of Disposition		Ob. Place of Disp	Horsesh			Jessu Date		cation - City or T	own. State
2	ages nt of t: if if	1	1 🗵 Burial 2 🗆 Cremation 3 🗆 Re	moval from State	-	matory or other p		1 0	2006			
Baitimore, Maryland 21215-0036	ntan n		4 □ Donation 5 □ Other (Specify) 21. Signature 1 Fund (1 Service Licensee		Meadowri	.age Memo				El	kridge,	MD
g	Deperment				1	1 Second						
			23a. Part1. Enter the disease, or complic	ations that caused the	death. Do not er						PID 210	Approximate
			sylock, or heart failure. List only one Immediate Cause (Final	cause on each line.		itor the mode or c	ying, secrets	cardiac c	n respiratory a	11031,		Interval Between Onset and Death
F	Physician /Medical		disease or condition resulting in death)	Seizure disc								
	Examiner			Due to (or as a co	nsequence of):							
		4	Sequentially list conditions, b.	Due to (or as a cor	nsequence of):							
/	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(2- 2- 2- 2- 2- 2- 2- 2- 2- 2- 2- 2- 2								
	al-tra	Xat	that initiated events c. resulting in death) Last	Due to (or as a co	nsequence of):						_	
8760,	death certificate be executed e ettending physicien and dor use as the burial-transit	dical										
89	ficate phy: s the	pa	a.			_						
×	eath certific ettending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pr	regnancy					,	3d. Date of deliv	verv
Rox	etter I for u	clar	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time		☐Ectopic pregnar ☐ Other (specify)					Month	Day Year
J	at the de by the e	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
	The law requires that the ste has been signed by those has been signed by the sage 2 should be detached.	효	Part II. Other significant conditions cont	nbuting to death but no	t resulting in the	underlying cause	given in Part I.		23e. Did t	obacco u	se contribute to	the cause of death?
g Q	w requires that been signed t should be det	d by							1 🗆	Yes 2[No 3□Pro	bably 4 Denknown
Ö	w req beer shou	ete							24a. Was	20	24h Wara aut	opsy findings available
ě	has ge 2	Completed							autor		prior to co	ompletion of cause of
_ 									12 Yes	2 □ No	15 Yes	2 No
Division of Vital Records,	sicie certii recto	Be	25. Was case referred to medical examiner?	ospital:		- 10	\u		(Check only o			
ō	Phys rthis raldi	. To	1 Yes 2 No 110 27. Manner of Death	1 🗀 inpatient	2 ER/Outpatie	III JUDON	4 🗆 140		ne 5 ☐ Resi			My AT SCENE
5	tending leath. Ior: After the funer	ti G	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) Injury	W	lork? ☐Yes 2 ☐I		ed. Describe	now injury	occurred	
<u>S</u>	# 0 5 ×	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home farm e				28f Location /	Street and	Number or Bur	al Route Number,
_	after after Dire	erti	4 Homicide determined	building, etc. (S	pecify)	reet, factory, offic		1.	City or To			ar noble warroer,
	To the Hospitel or At within 24 hours after of To the Funers! Direct completely filled in by		29a. Certifier 1 ☐ Certifying Physi	cian: To the best of my	v knowledge des	th occurred at the	time date an	d nlace	and due to the	Callegie,	and manner co	stated
	24 h 24 h Fur etely	edical		er: On the basis of exa and manner stated.	mination and/or i	ivestigation, in my	opinion, dea	th occurr	ed at the time,	date and	place, and due t	to the cause(s)
	ithin of the ompl	Me	29b. Signature and title of certifier			29c. Lice	nse number			29d. Date	signed (Month,	Day, Year)
)	->-0		· ONOT	`		C	C.M.E			JAN	. 3, 20	06
-			30. Name and address of person who con	nnleted cause of don't	(Item 22a) (Tuna	Print)						
	(4)		ANA CALE	310, MD	111 PEN	N STREET	, BALT	'IMOR	E,MARYI	AND	21201	
	Sta	te	31. Date filed (Month, Day, Year)	32. Begistrar's S								
	Registr		JAN 1 0 2006	1	K de	ante 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend/ Unpend item#10e.23a.27, per H, ME, MEST, 1/21/05 I and Mental Hygiene 0 6 LEROY KOONCE, JR. 06-00140 00283 RJ1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death _{Бау} 5, **Physician** January 2006 11:55 pм KOONCE LEROY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7 Joicy Court - Sidewalk Baltimore County Woodlawn If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 € M 2 ☐ F Director 220·36·2846 08.27.1941 Usual Residence of Decedent Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State r then "neturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD BALTIMORE GWYNN OAK the t 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 38jev Court 21207 ASU by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COMPLIER REPAIRMAN COMPUTERS 12/14 GRADE YRS f Health and Mental Hygi item 27 is marked other other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEROY KOONCE SR. HELEN BEAUFORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Joicy CT. ROSA KOONCE BALTO. MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of Importent: If it eny injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) KING PARK RANDALISTOWN, MD 01-11-06 21. Signature of Fuperal Service Licens 22. Name and Address of Facility FUNERAL SERVICE bushn 515) BALTO, NATE PIKE BALTO, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Seizure Disorder due to Intracranial Tumor Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of): Examin Hospitel or Attending Physicien: The law requires that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ettending p IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1, 2 Yes 2 □ No 24a. Was an autopsy performed? certificate 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence & Other (Specify) At SCENE Hospital: 1 tnpatient 2 ER/Outpatient 3 DOA ၉ 1 XYes 2 □ No this 28a. Date of Injury (Month, Day Year) : After the 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 6, 2006 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 RUBIO AWA MP

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32_Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death JAN **Physician** 0120 AM ENE 05 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner IA BALTIMORE AGIVES HEALTHCARE 8. Date of Birth (Month, Day, WG, 30 If Under 1 Year | If Under 24 Hrs. Security Number 7. Age (In yrs. last birthday) 9. Birthptace (State or Foreign 6. Sex **Funeral** 229-38-99/6 Usual Residence of Decedent Days Months Hours Min 1 M 2 1 Yrs. Director 10a. State 10b. County . Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, its Mudical Examiliar initial be netified at once. Attimore 1 Yes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 28 21216 ENUE Was Decedent Ey, Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Cotlege (1-4or 5+) Efementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rummons ORENZO 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addr As (Street and Number or Rural Route Jumber, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Cometery, crematory or other place Williams 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Book Owings 4 ☐ Donation 5 ☐ Other (Specify) TERAMS 21. Signa de Aruneral Service License ONE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Vascular Disease Athero Scherotic **Physician** ears /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 pronths? 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 X No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 SDER/Outpatient 1) Yes 2 No 1 Inpatient 3 DOA 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 T Homicide Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

219

State Registrar 31. Date filed (Month, Day, Year)

Susan Esporito

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DS 8764 January Baltimore, Maryland

		•	For State Registrar		partment of Health and Nertificate of Death	Mental Hygien Reg. ที่	2000 00200
	Physicia	an	1. Decedent's Name (First, Middle, Last) ADAPIIA KAA	MEGANIT	ſ	2. Date of Death Month	3. Time of Death
	/Medic Examin	_	4a. Facility Name (If not institution, give str	eet and number).	4b. City, Town, or Location of Death		c. County of Death
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location	11-13-19	10d. Inside City Limits
	a-f sho	ctor	PA Philadela	phia	hiladelphia		1 □ Yes 2 No
	with the	i Director	10e. Street and Number	+	101. Zip Code /	10g. C	Citizen of What Country?
	er death iteme 2: cer mus	Funeral	A.z		3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
0036	nours aft	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 KNo Specify:		Specify: Indian.
215-0036	be filed within 72 hours after death with the Maryland and Hygiene. d other than "natural", or iteme 23s or 28s-f show event, the Maulcal Exeminal most be notified.	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	tion (Gi completed) (Gi College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of work DO NOT use retired.	king 16b.	Kind of Business/Industry
12 pt	should be filed with nd Mental Hygiene marked other the imatic event, It.e.	Be Cor	17. Father's Name (First, Middle, Last)	0		ne (First, Middle, Maide	en sumame)
Maryland		ToE	Chandra Moul	Rannegant 19b. Ma	UMa Ulling Address (Street and Number or Ru	De VI II	vaganti.
	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		Chandra Kannego	anti Mair	Position (Name of	Bay, St. Ar	n Jamaica W. I Location - City or Town, Strite
altımore,	0 0		20a. Method of Disposition 1 Burial 2 Doremation 3 Re 4 Donation 5 Other (Specify)	noval from State cemetery, c	rematory or other place) re ral Chapel Bellin 1.	-10-06 FO	1 11 418
Balt	permit. Page Depertment Important: It any injury o		21. Signature of Funeral Service Licensee	1.40	22. Name and Address of Facility	BREST HIL	LL, MD 21050 HR. BNEWPORTDR.
CO.			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	tions/that caused the death. Do not cause on each line	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final / disease or condition resulting in death)	Due to (or as a consequence of):	er		
\$ 100 miles	Examiner	Jer.	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of).			
	xecuted and at-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
8760,	icate be executed physicien and s the burial-transit	dicai	d.				
Вох 6	ath certif ttending or use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		3 Dectopic pregnancy		23d. Date of delivery Month Day Year
P.0.	res that the de igned by the a be detached f	Physician/M	1 ☐ Yes 2 € No 9 ☐ Unknown	9 Unknown	5 Other (specify)		
	quires then signed and be de	þ	Part II. Other significant conditions cont	ibuting to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 20 No 3 Probably 4 Unknown
Division of Vital Records,	ne law requ hes been ge 2 should	Completed				24a. Was an autopsy performed?	
/ital	Physician: The le rr this certificete he aral director, page 2	Be Co	25. Was case referred to medical examiner?			1 Yes 2	√o 1 ☐ Yes 2 ☐ No
) ot	ding Physi h. After this c funeral dire	n: To	1 Pes 2 No Pending	spital: 1 Inpatient 2 ☐ ER/Outpal 28a. Date of Injury (Month, Day Year) 28b. Time	of 28c. Injury at	ome 5 Residence	
/isio	i or Attendir after death. Director: Af I in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm,	M 1 Tyes 2 No	28f. Location (Street	and Number or Rural Route Number,
ā	pitel or A ours after eral Direc filled in by		4 Homicide	building, etc. (Specify)	with accounted at the time, date and place	City or Town, Sta	
	To the Hospitei or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	one) 2 Medical Examine	ir: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occurred	rred at the time, date a	and place, and due to the cause(s)
•	5 ¥ 5 8	-	29b. Signature and title of certifier	pad mb	29c. License number P \ 85 4 3		Nuary 9 ZOO 6
1) 1		30. Name and address of person who con	pleted cause of death (Item 23a) (Typ	pe, Print)		Ithmore IND 2170
- 0			31. Date filed (Month, Day, Year)	32. Registrar's Signature			2150

State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend Item #20b Per FH G851 CP/11/2/1998 9HDeath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Gladys Elizabeth Kraus 4:56 AM Jan 06 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Healthcare Agnes If Under 1 Year | If Under 24 Hrs. 5. Social Security Namber 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2 F Days Min. Months Hours 218-36-7043 Yrs. Director 11, 1916 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23a or 28a-f show The Modical Examiner must be notified at Maryland N/A 1 Ves 2 No Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3102 Stafford Street 21223 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No 1 Never Married 2 Marned Maryland 21215-0036 1□ Yes 2 No Specify: White Specify. ¥Widowed 4 □ Divorced ģ Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Spondary (0-12) College (1-4or 5+) Hygiene Cashier Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Guy Taylor ages 1 and 2 should be nt of Health and Menta i: If item 27 is marked or other traumatic e Bessie Gladden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Kraus, III / son 5538 Oakland Rd. Arbutus, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
eny injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 01 - 09 - 05Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD Rebene The 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ischemu colitis **Physician** hours /Medical Due to (or as a consequence of) Examiner 48 hours Streptococca Dueumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of) Physician/Medical ettending pl IF FEMALE: Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) been signed by the should be detached o 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ds. Ď 1 Yes 2 No 3 Probably 4 Unknown Completed ibntlation 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate Vital 2 1 ☐ Yes 2 ☐ No Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ۵ 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 1 Natural 2 Accident 5 Pending death. 1□Yes 2□No investigation I Director: / 6 Could not be determined 3 Suicide within 24 hours after de To the Funerel Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19511 Jan 06, 2006 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Maryland Baltimore Avenue 22xRegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 1 0 2006

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			1 - For Stete Registrar	State of Ma	ryland /	•	rtment of H tificate of I		and Mental I	Hygier Reg.	200	5	00287
4	Physici /Medic	an	Decedent's Name (First, Middle, Last) I	Betty Baur	Knox				2. Date of Month Janu	1	Day 5, 200	rear	3. Time of Death 8:44 PM
	Examin	_	4a. Fecility Name (If not institution, give : Suburban Hospital	street and number)			4b. City, Town, or Bet	Location o			4c. County of		î y
	Funeral Director		5. Social Security Number 6. Sec	7. Age	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		Birth Day, Ye 5, 1		9. Birthp	lace (State or Foreign
	anyland ehow	J.	Usuel Residence of Decedent 10a. State 10b. County		10c. City, To							1	0d. Inside City Limits 1 ☐ Yes 2 🖾 No
	with the M la or 28a-f I be notified	Directo	Maryland Montgome 10e. Street and Number 4925 Battery Lane			В	ethesda 10f. Zip Code 208	14			Citizen of Wh		ntry?
920	within 72 hours after death with the Manyland ene. then "naturel", or Items 23a or 28a-f ehow ha Mudical Exterilise mais Ite molified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Wi						Americ	ean Indian, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23s or 28s-f show may injury or other traumatic event, the Mucical Exercitive Interfaces to Industrial and ODGs.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			(Give life. L	ent's Usual Occupa kind of work done of DO NOT use retired	<i>durina</i> mos	t of working		v. Kind of Business/Industry		
	uld be filed fental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Gustav Baur		,				ers Name <i>(First, Mic</i> .ce Wilson		den Sumame,)	
, Maryland	ind 2 shou alth and M 27 is mai		19a. Informant's Name/Relationship (Ty Bernard M.W. Knox/	•					704, Beth		•		
Baltimore,	Pages 1 anneal of He ant: If Item ary or oth		20a. Method of Disposition 1 Burial 2 Coremation 3 F 4 Donation 5 Other (Specify)	ternoval from State	Mont	gomer	sition (Name of natory or other place y um, Inc.	e)	Janua ry 9 2006	,		, Ma	aryland
Balt	permit. Departr Importe eny injt		21. Signature of Funeral Service Licens	00	M0019	Q RC	Name and Address	s of Facilit Pumph sin Av	rey Funer Je., Bethe	al H sda,	ome/ C	hase	sda-Chevy , Inc. 3501
8760,	cate be executed by yellow and buysicien and buysicien and burial-transit ithe burial-transit	dical Examiner	23a. Part1. Enfer the disease, or complishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, frame leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each lin	nonid consquent draid consquen	ce of):	er the mode of dyin	g, such as	cardiac or respirato	ry arrest,			Approximate interval Between Onset and Death
.O. Box 68	death certifi e attending id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal de	ath 3	Ectopic pregnancy				23d. Date Mont		ery Day Year
s, P	es tha	by	Part II. Other significant conditions co	ntributing to death bu	t not resultin	ng in the ur	nderlying cause giv	en in Part I		Did tobaco	\/	oute to th	ne cause of death?
I Record	The ate h page	Completed							E	Mas an autopsy performed	pri de	ere auto lor to col ath?	psy findings available mpletion of cause of
ion of Vital	nding Physicien: ath. r: Alter this certific e funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No I 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatier 28a. Date of Injur (Month, Day	y 28	Outpatien b. Time of Injury	28c. Injur Wor	er: 4 □ Nu y at		Residence	e 6 Other		V)
Division	al or Attenos safter death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injubutding, etc.	ry - At home . (Specify)	e, farm, str	eet, factory, office			on (Stree Town, S		or Rura	al Route Number,
	To the Hospital or Atte within 24 hours after des To the Funeral Director completely filled in by th	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami	sicien: To the best of ner: On the basis of and manner sta	examination	dge, death and/or in	n occurred at the tin vestigation, in my o	ne, date ar pinion, dea	nd place, and due to ath occurred at the ti	the caus me, date	e(s) and man and ptace, ar	ner as s nd due to	tated. o the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	omsko	May	7, M	29c. Licens	e number) 5 9	7/6	29d.	Oate signed	(Month, 200	Day, Year)
	15		30 Name and address of person who co	Nay, 1111	9 Koc	ckvi	Print) Pike	, G-1	100, Roc	KVI	ille, N	1D.	20852
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registra	rs Signature	Sacre	الك						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 8 per fn 8811 -18-06 vt
State of Maryland / Department of Health and Mental Hygien () () ()

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Noble Lee Kuster January 9, 2006 7:40A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11112 Troy Road Rockville Montgomery 8. Date of Birth (Month, Day, Year)
Oct. 28, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 1 XM 2□ F 578-12-7258 Director 1918 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County or 28a-f ahow 10d. Inside City Limits other traumatic event, the Medical Examinar must be rigitled at 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Deperment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a any injury or other traumatic event. If a Medical Examinant interts once. 11112 Troy Road 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) 11 Government Paint Leaderman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin F. Kuster Maude L. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Myers/Daughter 20619 National Pike, Boonsboro, Maryland 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 12, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Cemetery 2006 Brentwood, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee dennon w. M00798 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon **Physician** cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of or Attending Physician; The law requires that the death certificate be executed the burial-transit ettending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical use es IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached for 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should b 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?^1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate has t irector, page 2 s 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: ို 1 Inpatient 2 ER/Outpatient 3□ DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10ms 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lows ricia 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0 2006

WILLIAM G. KELLER Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-00114 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Keller WILLIAM 2006 January 1:05 a. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Route 1 near Little New York Road Cecil County Rising Sun If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Honths Davs Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Feb 28, 1961 533-72-3703 WIS CONSIN Director Usual Residence of Deceden 10a. State 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23s or 28s-1 ehov other treumstic event, the Medical Examinar must be notified at LANCASTER 1 Yes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 17563 W.S.A Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ■No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0:12) College (1-4or 5+) MACHINIST 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suma Be Pages 1 and 2 should be WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or 20b. Place of Disposition (Name of cemetery, crematory or other place) Spouse Baltimore, Method of Disposition ō = 5 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: if eny injury or 4 ☐ Donation 5 ☐ Other (Specify) rematory JAN 21. Signature a 5 neral Se ICENCED MORAKIAN Enter the disea lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart lailu Immediate Cause (Final disease or condition resulting in death) Physician le /Medical Due to (or as a con uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy ò Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by this certificate has been si al director, page 2 should 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an autopsy performed? 2□ No Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) At SCENE Certification: To 1⊠Yes 2□No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, y Year) 27. Manner of Death After 1 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 06 2 Accident
3 Suicide 1 ☐ Yes 2 No investigation 005 6 Could not be determined 28f. Location (Stree, and Number or Rural Route Number, City or Town, ate) 28 . Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. PM Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and little of certifier 29c. License number OCME 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

ARON WHE MY

31. Date filed (Month, Day, Year)

January 5, 2006

of death (Item 23a) (Type, Print) 111 renn Street Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 00290 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** N. Diane Leatherman January 2006 4:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6511 78th Street Cabin John Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 H 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F Davs Hours 492-44-4678 Director 68 DEC 22, 1937 Missouri Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or Itame 23a or 28e-f ehow 10a. State 10c. City, Town or Location 10b. County ed other then "natural", or itame 23a or 28e-f show event, the Modical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Director Maryland Montgomery Cabin John 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6511 78th Street 20818 Funeral <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Literary Work Author 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Walter Mann Hall 2 Nancy Adelia Shawhan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark W. Leatherman/Husband 6511_78th Street Cabin John, MD 20818 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages in Department of Himportant: if ite any injury or ot once. 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/9/06 Baltimore, MD 21. Signature of Fuperal Service License Edward A. Gres 22. Name and Address of Facility Cremation Society of MD, Inc. Gregorchik 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition Physician Ovarian Cancer Chronic /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury b. Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use es the burial-transit the attending physicien and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the sahould be deteched 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has pege 2 autopsy performe 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how in ury occurred After 1 Naturaf 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the within 24 hours after deatl To the Funeral Director: 6 Could not be 3 ☐ Suicide Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signaturé and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) January 9, 2006 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) John M. Wallmark, 9707 Medical Center Drive Rockville, MD 20850 M.D. 32. Registrar's Signature 31. Date fifed (Month, Day, Year) State JAN 1 0 2006 Registrar Service Service

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item# 20b perFH Q851,1/13/06 TF

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				Registrar 1. Decedent's Name (First, Middle, Last)	•	Och	incate of D		2. Date of Dea		3. Time of Death
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		Funeral		5 309 WesT N 5. Social Security Number 6. Sex	Orth Aven	U.C s. last birthday)_			B. Date of Birt (Month, Day	h 9. E	Birthplace (State or Foreign Country)
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	Mary	2 6 6 6		19a. Informant's Name/Relationship (Type	, Print) HUSBANI		Address (Street and	1 4	Route Numbe	er, City or Town, State	
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		205 20		which 1	/ Willia		sephH. B				Baltimore
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	0 0	ding Ph h. After fh funeral		27. Manner of Death 1 atural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?		d. Describe i	now injury occurred	
	Division of	or Attendialer death. I Director: A	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At	t home, farm, stre		s 2 □No 28		Street and Number or	Rural Route Number,
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		To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be defached for use as the burial-transit	dical (29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my ker: On the basis of exam	nowledge, death ination and/or inve	occurred at the time estigation, in my opin	, date and place, an nion, death occurred	d due to the	cause(s) and manner date and place, and c	as stated. due to the cause(s)
		To the within 2. To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. License r	number		29d. Date signed (Mo	onth, Day, Year)
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		27		30. Name and address of rson who co	pleted cause of death (II	tem 23a) (Type, P	rint)	Suite	- 27	BIALT. M	6717-1
		St.	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig		74400	ruite		OFFC 1, M	0 0 0 0
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Janay Lona 8 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | March 7, 1926 Johns Hopkins Bayulan Medical Center 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 195-20-5238 79 Yrs PA Director Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2X No Funeral Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Old North Point Road 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. own home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ira Stout Sr. 2 unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Long /daughter 600 Old North Point Road Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: if it
eny injury or o 1 Burial 2 Cremation 3 Removal from State GardensofFaith 1/11/06 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death—to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic 4 days **Physician** Cardiovavella Shock /Medical Due to (or as a consequence of): **Examiner** Toute Respiratory
Due to (or as a consequence of): Disten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Multi - organ S

Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-transit systen Division of Vital Records, P.O. Box 68760, Sepsis Bacterial by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) certificete has been signed by the a irector, page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1 Yes To the Hospitel or Attending Physician: within 24 hours eiter death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ٥ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Oate of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Matural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-003 Janay 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center, 4940 Gasten Ave. Batimore MD Hopkin low John Bayview 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State JAN 1 Registrar

DHMH 17 Rev 1/2001

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*	- Funeral Director		5. Social Security Number 218-14-1747 Usual Residence of Decedent		e (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y	9. Bir .923 1	thplace (State or Foreign ountry)
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Baltimore, Maryland	permit. Pages 1 and 2 should be I Department of Health and Mental Important: If item 27 ie marked o any njury or other traumatic eve once.	То	Zygmont Owsik 19a. Informant's Name/Relationsh Mrs. Donna Hamp 20a. Method of Disposition 120 Burial 2 Cremation 4 Donation 5 Other (Sp. 21. Signature of Funeral Service L	ton / Daught	20b. Place of Dispo cometery, cree Glen Have	West Ard sition (Name of natory or other pla n Memori Name and Addr	t and Number or Rulen Road; ace) al Pk 1-1 ess of Facility Si	McMakols ral Route Number, C Baltimore Date 20 1-2006 G .ngleton F	ity or Town, State, 2, MD 2122 c. Location - City or len Burni uneral Ho	Town, State e, MD ome, PA
ph	Physician /Medical Examiner	Ilcal Examiner	23a. Part1. Er er the disease, or condition resulting in death) Sequentially list conditions, farry, leading to limited attempts cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death)	a. Due to for as b. Due to for as c. Due to for as	the death. Do not entre. Shock a consequence of):					Approximate Interval Between Onset and Death 2 days
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	1		For State Registrar	ate of Maryland / Depa <i>Cei</i>	artment of Health and I rtificate of Death	Mental Hygier	211116	00294
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>	/Medic Examin		4a. Facility Name (If not institution, give street Northwest Hospital 5. Social Security Number 6. Sex		4b. City, Town, or Location of Death Randallstown If Under 1 Year If Under 24 Hrs.	0	4c. County of Death	
	Funeral Director		207-07-3937 Usual Residence of Decedent	7. Age (In yrs. last birthday) 87 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes	ar) Cour 1918	place (State or Foreign htry) MD
	Maryland f show	lor	10a. State 10b. County MD Baltimor	10c. City, Town or Lo	sterstown		1	0d. Inside City Limits 1 ☐ Yes 2√ No
	with the	I Direc	10e. Street and Number 423 Sacred Heart		10f. Zip Code 21136	10g.	Citizen of What Cour	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itama 23e or 28e-f ehow any injury or other traumatic avant, Ita Madical Exercitinal maint for incitified at ODGe.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 If	/as Decedent Ever in U.S. 13.1 med Forces?	Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	within 72 hou ene. then "neture he Medical E	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) C	ollege (1-4or 5+) (Give life.	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) DUSEWIFE	16b	. Kind of Business/In	dustry
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Maryland	nd 2 shouth and N 27 is main r traumain		19a. Informant's Name/Relationship (Type, P Jane N. Nase		ng Address (Street and Number or Ru Schoolhouse Road	ral Route Number, Cit		
Baltimore,	Pages 1 ar ment of Hea ant: If Itam: ury or other		20a. Method of Disposition 1 \(\mathbb{D}\) Burial 2 \(\mathbb{C}\) Cremation 3 \(\mathbb{R}\) Remove 4 \(\mathbb{D}\) Donation 5 \(\mathbb{D}\) Other (Specify)	20b. Place of Dispo cemetery, creating		Date 20c	inksburg,	own, State
Balt	permit. Depertingort. any inj		21. Signature of Funeral Service Licensee	1	2. Name and Address of Facility Eline Funeral Hom	e Reiste	Reisterstorstorstown, MI	
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	/Medical Examiner		Sequentially list conditions, D. —	Pute Onebo Due to (or as a consequence of): Althoused	oris Empo	lec		
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Division	To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely litled in by the fu	Certification:	3 Suicide 6 Could not be determined 28	e. Place of Injury - At home, farm, str building, etc. (Specity)	eet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
	the Hospi in 24 hou the Funer pletely lit	edical	(Check only 2 Medical Examiner: (n: To the best of my knowledge, deat On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	rred at the time, date	and place, and due to	the cause(s)
	or with the proof	Σ.	29b. Signature and title of certifier DOWN 30. Name and address of person who comple CAMANAMA T. (2007) 31. Date filed (Month, Day, Year)	aropy Mp	29c. License number D 5 4288	290.	Date signed (Month,	Day, Year) 4)192006
1	2'		30 Name and address of person who completed the state of	ted cause of death (Item 23a) (Type,	Prysittiven the	Spite (21te	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Hegistrar's Signature	park			

			For State Registrar	State of Mary		epartment of F Certificate of I			ene2006	00295
	Dhusiais		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic			Clarence Will	liam Le	eek		January		5:15 A M
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h
7				Nursing Home	ura lant himb		ockville	P. Data of Birth		tgomery
	Funeral Director		5. Social Security Number 6. S	MM 2DF	yrs. last birtho Yr	Months Days	Hours Min.	8. Date of Birth (Month, Day,		hplace (State or Foreign buntry)
			144-16-3952 Usual Residence of Decedent	83				January 17	, 1922 Ne	w Jersey
	yland		10a. State 10b. County	100	City, Town o	or Location				10d. Inside City Limits
	e Ma	cto	Maryland Mont	gomery		G	ermantowr	1		1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	death with the Maryland ma 23a or 28a-f ehow rmust be rotified at		19973 Wil	d Cherry Land			20874			d States
	er de Itemi	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces? 1 X Yes 2 ☐ No	in U.S.	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
გ გ	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or lieme 23a or 28a-f show event, it a Mudical Experient must be rediffed at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates: WW	TT	1 ☐ Yes 2X No	Specify:		Specify:	TThateo
2-003p	2 hou atura		15. Decedent's E	ducation	16a. D	ecedent's Usual Occup	ation	1	6b. Kind of Business	White Industry
2 2	within 72 lene.	Completed	(Specify only highest gr. Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)		Give kind of work done ife. DO NOT use retired	during most of work i)	ing	Montgome	ry County
7	giene gritha	O I	12			Police	Officer		Po1	
and	oe filed lal Hygid d other event, I	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M	aiden Sumame)	
<u>X</u>		ပ္		Harry Leek				Hat	te Case	
Jar	s 1 and 2 should if Health and Mer Item 27 Is marke other treumatic		19a. Informant's Name/Relationship	Type, Print)	19b. N	Mailing Address (Street	and Number or Run	al Route Number,	City or Town, State, 2	Zip Code)
ຜົ	s 1 and 2 of Health Item 27 I		Debra Hayre/ Da 20a. Method of Disposition	ughter	1 Place of D	9973 Wild Consposition (Name of			town, Mar	vland 20874
<u>o</u>	or of		1 ☐ Burial 2 🎇 Cremation 3 🛭	Removal from State	cemetery, Monto	crematory or other place	a) Jar	nuary	oc. Location - City of	TOWN, State
saitimore,	rtmer rtant nlury		4 □ Donation 5 □ Other (Speci 21. Signature of Furieral Service Lice			torium Inc	.)	2006	Bethesda,	Maryland
g	permit. Pages. Department of Important: If Ite any Injury or of		21. Signature of rotal assistics little		0335	Rockvill Rockvill	e, Inc. 3 e. Marvla	300 West	Montgomer -2805	neral Home/ y Avenue
E	*		23a. Part1. Enter the disease, or com shock, or heart failure. List only	blications that caused the						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Aspiration	n Pneur	monia				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor						
	Examiner		Sequentially list conditions,	_{b.} Sepsis						
	ed sit	ine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a co.						
۴	and I-tran	Examiner	that initiated events resulting in death) Last	c. ere rova Due to (or as a co						
58750,	ificate be executed g physicien and as the burial-transit	ledicai E		d Dementia						
_	ing pl	Med	IF FEMALE:			10,101.00			T	
X Q Q	at the death certifi I by the ettending I	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr	Fetal death	3 Ectopic pregnancy	,		23d. Date of dea	ivery Day Year
_	the e	ysic	1 Yes 2 No	4□Pregnant at time 9□Unknown	of death	5 Other (specify)				,
ב	that the		Part II. Other significant conditions	contributing to death but no	t resulting in t	he underlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Vital Records,	requires that the een signed by th nould be detache	d by	•	•		, , , , , , , , , , , , , , , , , , , ,				obably 4 X Unknown
ဂ ္ဂ	w require been sk should t	Completed						24a. Was an	24b. Were au	utopsy findings available
8	The law ite hes b page 2 si	шс						autopsy	ed? prior to death?	completion of cause of
g	0 -	0	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 h (Check only one	22	2 No
	Physician: r this certific ral director,	lo B	examiner? 1 □ Yes 2 🎇 No	Hospital:	2 ☐ ER/Outp	atient 3 DOA Oth	00		nce 6 Other (Spe	cify)
0	ding Ph h. After th funeral	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Ye.	ar) 28b. Tin			28d. Describe hor		,,
<u> </u>	Attending or death. ector: After by the fune	atlc	1 Natural 5 Pending 2 Accident investigate	in			Yes 2 □No			
Division	i i ite	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		At home, farm pecify)	n, street, factory, office		28f. Location (Str. City or Town,	eet and Number or Ri State)	ural Route Number,
_	Hospitel or 24 hours afte Funerel Dir tely filled in		29a. Certifier 1X Certifying P	hysician: To the best of m	/ knowledge.	death occurred at the tir	ne date and place.	and due to the ca	use(s) and manner as	stated
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical		miner: On the basis of exa and manner stated.	mination and/	or investigation, in my o	pinion, death occur	red at the time, da	te and place, and due	e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)
			> Twom	10 · 10 s	nh		D0047330		January	5, 2006
	16X'		30. Name and address of person who		(Item 23a) (T		20071JJU		January	J 9 4000
_	19.		Thomas V. Joseph	, M.D. 50 We	st Edmo	onston Driv	e Rockvil	le, Mary	land 20852	2
18	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	all s				
18	Registi	ar	JAN 1 0 2006	But allow In	· ATOM	-04				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1tem 18 per th 851 1-10-06 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** ROSE LURAY Danuary 5,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Sinai Hospital of Baltimore N/A If Under 1 Year If Under 24 Hrs. North Days Hours Min. 01/10/1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕶 F 213-12-3488 Director 86 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, Ira Mudical Examinar must be ruttlined at ance. 1 Yes 2 No Be Completed by Funeral Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 7 SUDBROOK LANE 21208 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. WHITE 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANo 3

Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame)

Anna
UNKNOWN
BU 17. Father's Name (First, Middle, Last) LEBOWITZ MEYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94 TOWNSEND GULCH - BELLEVUE, ID 83313 H. ALLEN LURAY / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BNAI ISRAEL 01/08/2006 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia **Physician** day /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) physicien and s the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of). P.O. Box 68760. Completed by Physician/Medical ettending physic if for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 1 Yes 2 No 2 No Division of Vital 1 ☐ Yes Be director 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending , 6, ,s efter dea., ,erel Director: A' ,v filled in by the 1 ☐ Yes 2 ☐ No M investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hoepital within 24 hours a To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res-000 January 5, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NASSIFIADEZ K 0.9 SINAL MOSPITAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar 0 2008

Rose

Patient Known

			1 - State of Maryland	-	artment of F			ene 0 0 6	00297
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia /Medic		BELLE	LEV	ITT		JANUARY	8, 2006	5:20 A M
	Examin	_	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o		ith	4c. County of Death	
			JEWISH CONVALESCENT CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. las	t hirthday)	BALTIM If Under 1 Year		S. 8 Date of Birth	BALTIM	
	Funeral Director		215-03-4511 1 M 2 T F 88	Yrs.	Months Days	Hours Mir		1917	nplace (State or Foreign untry) MD
	ט		Usual Residence of Decedent						
	arylar ehow	5		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	MD BALTIMORE 10e. Street and Number	OWIN	GS MILLS		10	g. Citizen of What Co	
	death with the Maryland ms 23a or 28a-f ehow rrivet be notified at		17 INDIAN PONY COURT		101. Zip 0008	21117		g. Olizen or What Col	USA
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H		Specify Yes or No- rto Rican, etc.)	14. Race - Amer	ican Indian,
2	or Ite		1 Never Married 2 Married 1 Yes 2 No		1 ⊡ Yes 2 🛣 No	Specify:	no rican, etc.)	Black, White Specify:	WHITE
000	within 72 hours after ene. than "natural", or Ite	ed by	3 X Widowed 4 Divorced Year or Dates:						
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and	be file tal Hy od othe event	Be C	17. Father's Name (First, Middle, Last)				ame (First, Middle, M.	<i>'</i>	
<u>X</u>	should Ind Menion Menio	Jo	FRANK	CAPLA		FANNI			ETTLER
Z Z	C1 C0 C0 C0		19a. Informant's Name/Relationship (<i>Type, Print</i>) SHELDON LEVITT / SON					City or Town, State, Z MILLS, MD	
ā,	tem 27		20a. Method of Disposition 20b. Plac	ce of Dispo	sition (Name of	1	-	Oc. Location - City or 1	
Ē	Pages nent of int: If it iry or o		1 M Burlai 2 Cremation 3 Hemoval from State		natory`or other plac C ADATH		/9/2006	DUNDALK	- MD
altimo	permit. Pages: Department of Inportant: If ite any injury or of		21. Signature of Funeral Service Licensee		. Name and Addre			ON & BROS.	
מ	8 8 E 8		Death M. auch		900 REIS			IKESVILLE.	•
			23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dyir	ng, such as cardia	_	st,	Approximate Interval Between Onset and Death
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o n	death e atten ed for u	iclan/M	23b. Was decedent pregnant 1	eath 3	Ectopic pregnancy Other (specify)	<i>f</i>		23d. Date of deline	Day Year
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ω, J	w requires that s been signed b should be deta	by P	Part II. Other significant conditions contributing to death but not result	ing in the u	nderlying cause giv	ren in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Hecord	equir				·		1 Tes	2 ☐ NO 3 ☐ Pro	bably 4 Dunknown
ပို့		ompleted					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
	sician: The law certificate has b irector, page 2 s	O					perform 1 Yes 2		2□ No
VII	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes Yes Yes Hospital: 1 Inpatient 2 El	D/Outpation	nt 3 DOA Ott	or /	eath (Check only one		
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o O	ath. or; Aft	atlo	2 Accident investigation	Injury	M 1	Yes 2 □No			
Division	al or Attending Phy s after death. Il Director; After this od in by the funeral of	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify)	ie, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
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	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; Atter th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowl (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	eage, death n and/or in	vestigation, in my o	me, date and plac prinion, death occ	curred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier		29c. Licens	e number	29	d. Date signed (Month	, Day, Year)
			by South	MA		5/40		JAN. 7	2006
	6		30. Name and address of person who completed cause of death (Items	3a) (Type,	Print)	D/2 160	0	11	1200
	or or		1 Day Sin Sit (Sign)	(5210	11/6/15	the, 1	>11/1/11/	1815
	Sta Registi		31. Daté filed (Month, Day, Year) 32. Régistrér's Signatu	k A	onelle		,		

l'	1	For State Registrar		aryland		artment of F rtificate of		R	eg. No.	Jb	00298
Physician	1.	Decedent's Name (First, Middle, L	ast)		,	TT CU		2. Date of Dear	th Day	Year	3. Time of Death
/Medical		SUSAN				ITWIN		Januar	7	2006	11:22 AM
Examiner	48	a. Facility Name (If not institution, g	1.	1	1	1 11	r Location of Death		4c. Cou	nty of Death N/A	
	L			Spita		Baltin		4			
ineral		Social Security Number 6. 062-36-5446	Sex 7. Ag	e (In yrs. Ii 60	ast birthday Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	1945	9. Birth	place <i>(St</i> ate or Foreigi ntry) w York
ector	\perp	sual Residence of Decedent						Aug 1,	1940	Ne	w IOIK
4	1	0a. State 10b. County		10c. City	, Town or L						10d. Inside City Limits
ţ		NY Kings	3		New Y	ork					1 Yes 2 □ No
adical Examiner must be notified at leted by Funeral Director	1	Oe. Street and Number 1570 East 14th	Street	1		10f. Zip Code	11230	1	10g. Citizen USA	of What Cou	ntry?
erai	-		12. Was Decedent	Ever in 11	S 13	Was Decedent of H		pecify Yes or No-		Race - Ameri	ican Indian
5	1	 Marital Status 1 ☐ Never Married 2 X Married 	Armed Forces?		3. 13.	If Yes, specify Cub	tispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	E	Black, White,	
by F		3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2/☐ If Yes, Give Year or Dates:			1 ☐ Yes 2 📆 No	Specify:		Spe	ocity: Wh	ite
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njury or other treumanic event, the many of the complete of th	1	 Father's Name (First, Middle, La Harry Rosenblat 	•				18. Mother's Nam Florence	ne (First, Middle, ce Berko		name)	
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		Robert Litwin (I	Husband)		1570	14th STr	reet Bro	oklyn, N	ew Yor	ck 112	30
5	2	Oa. Method of Disposition		20b. P	lace of Disp	osition (Name of matory or other pla	ce)	Date	20c. Location	on - City or T	own, State
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급	1	21. Sign wife of Funeral Service Lic	ensee 🔎		2	2. Name and Addre	ess of Facility		NT.		
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ai Examin		Cause (Disease or injury	· Scler	ode	ma						1 month
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for us		23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant a	2 Feta	death 3	☐Ectopic pregnanc☐ Other (specify) _	у		23d.	Date of delive	very Day Year
ysic		1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	t time or o	eam 5	□ Other (specify) _					
detached Physic		Part II. Other significant condition	s contributing to death t	out not resi	ulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use o	contribute to	the cause of death?
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should leted	-		-		·			24. 146			
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S S		20-21						1 Tes	2 No		2 No
Be Be		25. Was case referred to medical examiner?	Hospital:				han	th (Check only or			
2	1	1 Yes 2 No 27. Manyler of De h	1 / Inpati		ER/Outpati	ant 3LIDUA	4 🗆 Nursing n	ome 5 Resid			ify)
e G	'	1 ☑Natural 5 ☐ Pending	28a. Date of Inji (Month, Da	ay Year)	28b. Time Injury	Wo	ryat irk?]Yes 2∐No	200. Describe fi	low injury oc	curred	
i a		2 Accident investiga 3 Suicide 6 Could no	t be One Diese of le	ium. At he	ome form		165 2 100	39f Location /S	Stroat and Mi	umbar or Ru	ral Route Number,
led in by the funeral Certification:		4 ☐ Homicide determin	ed 286. Place of in building, e	tc. (Specif	y)	treet, factory, office		City or Ton	vn, State)	umoer or Hu	rai Houte Number,
		29a. Certifier in Certifying	Physician: To the best	of my kna	white do	dh Americad at the t	in a flate and class	and dealer the	cause(a) acc	La construire me	etetort
mpletely fill	5	(Check only 2 Medical Ex	miner: On the basis of and manner s	of examina	tion and/or	nvestigation, in my	opinion, death occu	rred at the time, o	date and pla	ce, and due	to the cause(s)
completely filled in by the fu		29b. Signature and title of certifier	0 Me	dica	(1	se number				Day, Year)
		Kelly Chland	no completed cause of The Johns H	octor		Re	5-000	(Janua	ry 7	2006
	1	30. Name and address of person w	no completed cause of	death (Iten	n 23a) (Type	a, Print)			2.112.	MONE	
2		Kelly Schlendorf	The Johns V	topkin	is Hosi	1 001 latin	Worth Walf	e Street	MAL	ryland	1 21231
State		31. Date filed (Month, Day, Year)	32 Regist	rar's Signa	ture	-1 1 0 -0 1			1. 100	1	

DHMH 17 Rev 1/2001

State

Registrar

JAN 1 0 2006

ORIGINAL

L			For State Registrer	State of Marylar		artment of tificate of		and Me		ene 0 0	6 00	1299
	Physicia		1. Decedent's Name (First, Middle, Last TIMOTHY MORR		•				. Date of Death Month January	Day 6. 200	Year	13 P M
	/Medic Examin		4a. Facility Name (If not institution, give 9634 Reisterstown			4b. City, Town, Owings If Under 1 Yea		of Death	zamuen y	4c. County of	Death	15
	Funeral Director		5. Social Security Number 054-74-4063 Usual Residence of Decedent	x 7. Age (<i>in yr</i> s. XM 2□ F 2	V	If Under 1 Year Months Day	r If Under a	Min.	Date of Birth (Month, Day,) 11/28/	(ear)	9. Birthplace (Sta Country) NEW YO	
	Maryland I-f ahow	tor	10a. State 10b. County MD BALTIM		ty, Town or Lo	cation)	de City Limits Yes 2√∑ No
	death with the Maryland ims 23a or 28a-f ahow	ai Director	10e. Street and Number 3834 SANDY HO	OK ROAD		10f. Zip Code 211			10	g. Citizen of Wi USA	nat Country?	
2-0036	urs after al', or ita Examine	by Funeral	11. Marital Status ¹∰ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes ※☐ No If Yes, Give Year or Dates:		Was Decedent of Yes, specify Cu	ıban, Mexican	i, Puerto Rio	fy Yes or No- can, etc.)		- American India , White, etc. BLA	
0-61212	within 72 ene. than "nai	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 2 T H		(Give	dent's Usual Occ kind of work don DO NOT use reti PENDANT	ne during most red)	t of working		6b. Kind of Bus		
yland	should be filed nd Mental Hygi nmarked other umatic avent, I	To Be C	17. Father's Name (First, Middle, Last) HENRY MORRIS				LAV	INIA	First, Middle, Ma JACK	SON		
е, маг	s 1 and 2 sho f Heelth and item 27 ie m other treum		19a. Informant's Name/Relationship (T. LAVINIA JACKSO 20a. Method of Disposition	N / MOTHER	383	ng Address (Stre 4 SAND) esition (Name of			, RAND	ALLSTO		
Baltimore,	Pege Iment o Ient: if jury or		1 Burial 2X Cremation 3 4 Donation 5 Other (Specify 21. Signature Fundal Service Licen:	Removal from State M	ETRO (CREMAT	DRY 1	/16/	06	CATONS	SVILLE,	MD
eg G	Deperiting Deperiting Important Impo		23a. Party Enter the disease, or compshops, or hand failure. List only	11/0.1Xa	The A	600 LIE	BERTY	HEIG	HTS AV	E., BA	ALTIMOR Approx Interva	RE, MD
	Pnysician /Medical Examiner		Immediate Caure (Final disease in condition resulting in Teath)	aGVNSHIT Due to (or as a conse	WOUN	0(1)0			ANDI		Onset	and Death
8/60,	ate be executed hysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (ct as a consect. Due to (or as a consect.)								
O. Box 68	death certific e attending p id for use es	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnal				23d. Date Mont	of delivery th Day	Year
rds, P.	quires that n signed build be deta	þ	Part II. Other significant conditions co	ontributing to death but not re	sulting in the u	nderlying cause	given in Part I.		23e. Did toba	1.0	oute to the cause	of death?
Vital Records,	sicien: The law requires that the certificate has been signed by thirector, page 2 should be detache	Completed							1	ed? de	ere autopsy find for to completion eath?	of cause of
of Vit	Physicial this certi	: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	IL SELDON	Other: 4 🗆 Nu	ursing Home	Check only one 5 □ Resider d. Describe hove	ice eXOthe	(0,000)	cene
Division of	r Attending Physician: er death. ractor: After this certific i by the funeral director,	Certification:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month Day Year)	Z3/	O M 1	Yes 2	15 00	SUBS	SEITU	NAS SI	
Ö	To the Hospitel or Al within 24 hours after of To the Funeral Dirac completely filled in by			building, etc. (Spec ysician: To the best of my kr	PAR V	CINA L	OT time, date an	nd place, an	City or Town,	State) C/(g	NASMILI Iner as stated.	IENSIUWA IS, MD
	To the Ho within 24 I To the Fu completely	Medical	(Check only one) Medical Examone) 29b. Signature and Mile of certifier	iner: On the basis of examinand manner stated.	nation and/or in		y opinion, dea	ath occurred	-		nd due to the cat	
•	1		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	OCM	Œ		J	anuary	7, 2006	
	Sta		31. Date filed (Month, Day, Year)	32. Høglstrar's Sigr	nature	111 Pen	n Stre	et, B	altimor	e, Mary	land 212	201
	Regist	rar	JMN + V	2006	10 Mg	Comment of the Parket						

UNK 06-0084 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygierie 0.0.5

00300

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Denostrate of Health and Mantai Hunjana.
	Phy /N Exa
P.O. Box 68760,	hat the death certificate be executed

Vatell	Murray		1 - For State Registrar	State of Ivi	arylaric		rtificate of	Death		Reg. No.	Ub	00000
	Dhuaiais		1. Decedent's Name (First, Middle	e, Last)					2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		VATELL A.						JANUAR	Y 3,	2006	7:20P. M
	Examin	er	4a. Facility Name (If not institution 2600 BLK GREEN)				4b. City, Town, o	r Location of Death RE			ounty of Death	
	Funeral Director		5. Social Security Number UNKNOWN	6. Sex 1 X M 2 □ F	15	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 03/02	h y, Year)	9. Birthp	place (State or Foreign htry) RYLAND
_	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ecation				1	0d. Inside City Limits
	ith the Marylan or 28a-f ehow	ector		I/A		BAL	CIMORE (CITY		10-00		1 XYes 2 □ No
	deeth with the Maryland ma 23a or 28a-f ehow	Funeral Director	10e. Street and Number 3223 WESTMO	NT AVENUE			10f. Zip Code 2121				of What Cour	itry?
9036	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylai Depertment of Heath and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f ehow any injury or other treumatic event, the Madical Expiniting runal be notified at one.	þ	11. Marital Status 1	If Yes Give)		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 💆 No	tispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Black, White,	
5-0	"natu	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Dece (Give	dent's Usual Occup	pation during most of work d)	ing	16b. Kind	of Business/Ind	dustry
12	withir ene. then	dmc	Elementary/Secondary (0-12) 10TH	College (1-4or	5+)	me.	STUDENT			ST	UDENT	
9	e filed ii Hyg other	BeC	17. Father's Name (First, Middle,	Last)	- '			18. Mother's Nam	e (First, Middle,			
ylar	Menta Menta arked	70 E	ANTHONY BRY	AN					NETTE			
, Maryland 21215-0036	end 2 sho salth and n 27 is m		19a. Informant's Name/Relations SHANELLE MUR			1	-	and Number or Rur IONT AVE				
Baltimore,	ages 1 ent of He nt: If iten ry or oth		20a. Method of Disposition 1 ☐ Burial ※XXCremation 4 ☐ Donation 5 ☐ Other (5	3 Removal from State	CE	emetery, cre	osition (Name of matory or other pla CREMATOF	ce)	0/06		tion - City or To	Dwn, State
a H	rmit. I portar y inju		21. Signature Funeral Service		1			ess of Facility HO		UNERA	AL HOM	E 21207
	9 Q E # 9		/ July	//01/	Car	1	1600 LIE	ERTY HE	IGHTS	AVE.	BALT	IMORE, MD
		5 6	23a. Pay1. Enter the discase, o shock, or eart failure. List Immedite ause (Final	r complications that cause t only one cause on each i	d the death ine.					rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		diseas condition resulting in death)	aDue to (or as	1+p		unshot	Wound	LS		-	
	Examiner		Comment the line and diving	b	a sonagqu	101100 OI).						
1/	pg ij	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ience otj:						
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P.O. Box	or Attending Physicien: The law requires that the death certifer death. Director: After this certificate has been signed by the ettendin in by the funeral director, page 2 should be detached for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3[□Ectopic pregnanc □ Other (specify)	у		230	d. Date of delive Month	ery Day Year
a .	s that ned by e deta	by Ph	Part II. Other significant conditi	ions contributing to death I	but not resu	ılting in the u	ınderlying cause gi	ven in Part I.	23e. Did t	obacco use	contribute to th	ne cause of death?
rds	w requires that been signed to should be det	ted t							10	Yes 2 □X	No 3□ Prob	pably 4 □Unknown
Division of Vital Records,	he law r e has be ige 2 sh	Completed								an 2 osy ormed?	24b. Were auto prior to co death?	psy findings available mpletion of cause of 2 No
ta	ician: Th certificate ector, pag	Be Co	25. Was case referred to medica	al				26. Place of Deal			1 \Z\Yes	2 No
<u>></u>	Phyaici this ca al direc	To B	examiner? 1 XYes 2 □ No			ER/Outpatie	nt 3□ DOA Ot	ner: 4□ Nursing Ho			Other (Specify	y) SCENE
n o	ding P		27. Manner of Death 1 ☐ Natural 5 ☐ Pendi		ury ay Year)	Found	, Wo	ry at rk? I Yes 2 No	28d. Describe			+
isio	death death ctor: y the	licat	3 Suicide 6 Could	I not be	06	6:13	reet, factory, office	Tes Zixino		. 1	+ Slo	
2	e after i Dire	erti	4 Homicide determ	building, e	tc. (Specify	")	unuel		Green	wn, State) 2	600 BU	al Route Number, L altruwe HD
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification;	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ing Physician: To the best I Examiner: On the basis of and manner s	t of my know	wledge, dea	th occurred at the ti	me, date and place, opinion, death occur	and due to the	cause(s) ar	nd manner as si	tated.
	To th within To th comp	Æ	29b. Signature and title of certific	ər			29c. Licen	se number		29d. Date s	signed (Month,	Day, Year)
	(Carol	Hallaun	id		0.	C.M.E.	J	ANUAR	Y 4, 20	106
	N		30. Name and address of person	who completed cause of	death (Item	23a) (Type	•	N STREET	BALTIMO	RE MA	RYLAND	21201
	Sta Regist		31. Date filed (Month, Day, Year	0 2006 32. Per ist	trar's Signa	ture	berte					
-		_				- 10						

06-00159 B.K.S HENRY MCROBIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

Eldersburg

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

21784

Certificate of Death

	ı
Physician	ı
/Medical	ŀ
Examiner	ı

Directo

Henry Loree McRobie 4a. Facility Name (If not institution, give street and number)

5. Social Security Number

212-38-5755

10a. State

Maryland

11. Marital Status

10e. Street and Number

Usual Residence of Decedent

10b. County

5428 Bartholow Road

Carrol1

1. Decedent's Name (First, Middle, Last)

HOWARD COUNTY GENERAL HOSPITAL

1XM 2□F

7. Age (In yrs. last birthday)

10c. City, Town or Location

64

12. Was Decedent Ever in U.S. Armed Forces?

4b. City, Town, or Location of Death COLUMBIA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year)

10f. Zip Code

 Date of Death
 Month 2006 Year 4c. County of Death

HOWARD

1941

JAN.

MAR 16.

3. Time of Death 8:12 P M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 XNo

Pennsylvania

Funeral Director

the Maryland 28a-f show ō

the Medical Examiner must be notified at death o other than

within 72 hours after permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other treumatic event, odcs.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Examiner i or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physicien and 3 in by the funeral director, pege 2 should be detached for use as the burial-transit Box 68760 Physician/Medical Division of Vital Records, P.O. Be Completed filled in by To the Hospitel o within 24 hours at To the Funeral D

Funeral 1 Tyes 2 No
If Yes, Give
Year or Dates: 1958-62 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Š 3 ☐ Widowed 4 X Divorced ted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Complet Elementary/Secondary (0-12) College (1-4or 5+) Attorney 5+ 17. Father's Name (First, Middle, Last) Be Loree Freeland McRobie 19a. Informant's Name/Relationship (Type, Print) Kevin L. McRobie/Son 9027 Early April Way 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/9/06 21. Signature of Funeral Service Licensee Edward A Gregorchik 299 Frederick Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PMURIES MUUNPLE Due to (or as a consequence of) Sequentially list conditions, and productions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 📉 ER/Outpatient 3 ☐ DOA ٩ 1XXYes 2 □ No 28c. Injury at Work? Certification; 27, Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending Injury 1902 PM 1-6-6 1 ☐ Yes 2 No Delver of con, couls low with , investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide RODDWAY NRT32 HOWDER W-MO 29a. Certifier Medical

10g, Citizen of What Country? USA

14. Race - American Indian, Black, White, etc. Specify. White

16b. Kind of Business/Industry

Law Practice 18. Mother's Name (First, Middle, Maiden Sumame)

Mary Bridget Flounders

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Columbia, MD 21046 20c. Location - City or Town, State

Baltimore, MD

22. Name and Address of Facility Cremation Society of MD, Inc.

Baltimore, MD 21228 Approximate Interval Between Onset and Death

> 23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 2□ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No

Year

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred TRACTORTEDIES

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Tymedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29b. Signature and title of certifier Mayinte Yhele WY The

O.C.M.E

29d. Date signed (Month, Day, Year) 7, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOREL 111 PENN STREET, BALTIMORE, MARYLAND 21201 MARGIRIAN 1)

31. Date filed (Month, Day, Year) State



Registrar

			For State Registrar	State of Ma	aryland		artmeni rtificate			ind Me	ental Hy	giene	06	00302	
	Physici /Medic	_	1. Decedent's Name (First, Middle, LES LY E	Last)	CA	-4LE	7				2. Date of De Month	Day	Year 06	3. Time of Death	
	Examin	ric.	4a. Facility Name (If not institution, Hospice of the 5. Social Security Number	give street and number) Chesapeake a	at Anr		4b. City,	len	Burni	ie	8. Date of Bir	Anne	ty of Death Arur		
÷	Funeral Director		212-26-1152 Usual Residence of Decedent	1□M 2XF	78	Yrs.	Months	Days	Hours	Min.	(Month, Da	iy, Year) 4, 1927	Mar	place (State or Foreign ntry) yland	_
	the Marylar 28a-f show	Director	MD 10b. County Anne	Arunde1		Town or Lo	10f. Zip	Code				10g. Citizen o		10d. Inside City Limits 1 Yes 2 No	_
36	be filed within 72 hours after death with the Maryland ital Hyglene. id other then "natural", or iteme 23a or 28a-f show event, The Madical Examinar must be incitiled at	by Funeral DI	885 Doris Drive 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces?				2. lent of His	1012 spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No lican, etc.)	- 14. Ra	SA ace - Ameri ack, White,	can Indian, etc.	_
Maryland 21215-0036	I within 72 hou iene. r then "natura ine Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education	i+)	(Give life.	dent's Usua kind of wor DO NOT us	rk done du e retired)	uring most	of workin	g	16b. Kind of		odustry	_
yland 2	should be filed wand Mental Hygier marked other ti umatic event, In	To Be C	17. Father's Name (First, Middle, L William Leslie	Kelly					Mabe	el Le	utner	, Maiden Surna	ame)		_
re, Mar	d 2 d th ar treut		19a. Informant's Name/Relationshi Robert McCauley 20a. Method of Disposition	/spouse			Oris	Driv	e Arı	nold,		er, City or Tow 21012 20c. Location			_
Baltimore,	permit. Pages 1 an Department of Heal important: if item 2 any injury or other once.		1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (Sp. 21. Signature Funeral Strate S	ecify)	ector					y oard	655 W.	Balti	more 9	Street	-
	Physician		23a. Part1. Enter the disease or conditions the cause (Final disease or condition	complications that caused	10.	Do not ent	eltimo	ore, e of dying	MD 2	21201 cardiac or				Approximate Interval Between Onset and Death	
8760,	death certificate be executed e attending physiclen and ad for use as the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as b. Due to (or as c. Due to (or as d.	a conseque	ence of):									
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Vital Records,		Completed									1 Yes	psy ormed? 2 No	prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of	
Division of Vit	E = E	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig.	ation	ry :	R/Outpatier 28b. Time o Injury		8c. Injury Work	r: 4 □ Nu	rsing Hon		one) idence 6\(\frac{1}{2}\) how injury occi		hospice	_
DIX	pitel or Att ours after de erei Directe	Certification:	3 Suicide 6 Could n 4 Homicide determin	ned 288. Place of inj building, et	c. (Specify)			_			City or To	wn, State)		al Route Number,	
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) Certifying (Check only one)	Physician: To the best examiner: On the basis of and manner sta	fexaminati	on and/or in	vestigation,	in my op	number	th occurre	d at the time,	date and place	e, and due t	o the cause(s)	
)			30. Name and address of person v	tho completed cause of g	leath (Item	23a) (Typex	Print	D -	214	38	HWAY	A	Will.	y 04,200	0
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registr	ar's Signati	44) hr.	DE	LEN	VSE I	1776	HWAY	/10M	TULY)	MINITA	_

		-	For State of Maryla Registrar	•	rtment of Hea		ntal Hygien	21116	00303
	Physicia		. Decedent's Name (First, Middle, Last)				Date of Death Month D	ay Year	3. Time of Death
	/Medic	al -	Curtis Levoy 11ayo		4b. City, Town, or Loc	<u>~</u>		7 2006 c. County of Death	7,25 AM
	Examin	er	a. Facility Name (If not institution, give street and number) VA Medical Center Loch	Raven	Baltimo		"	c. County of Death	
	Funeral		S. Social Security Number 6. Sex 7. Age (In)	rs. last birthday)		Under 24 Hrs. 8.	Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign
	Director	_ L	245-20-8481 XXM ^{2□ F} 79	Yrs.	World Days	0	9 01	26	ЙC
	land ow		Jsual Residence of Decedent	City, Town or Loc	cation				10d. Inside City Limits
	Many a-f eh	to	MD Baltimore	Randa	allstown				1 □Yes X□No
	or 28	Director	Oe. Street and Number		10f. Zip Code		10g. C	itizen of What Cou	ntry?
	s 23a	rail	5107 Old Court Road Apt]		211		. Van as Na	U.S.A.	een Indian
'	fter de r Itam Irrer	Funerai	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married	n 0.5.	Vas Decedent of Hispar Yes, specify Cuban, M	Mexican, Puerto Ric	an, etc.)	Black, White,	
Maryland 21215-0036	J within 72 hours after deeth with the Maryland jiene. I then natural', or Itams 23e or 28e-f ehow It e M. Jical Evarither must be natified at	d by	XXWidowed 4 □ Divorced If Yes, Give Year or Dates:	1	☐ Yes 2½ No S	pecify:		Specify: B	lack
5-	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	ent's Usual Occupation kind of work done durin OO NOT use retired)	n ng most of working	16b.	Kind of Business/In	dustry
12	I within iene.	фшо	Elementary/Secondary (0·12) 5th grade College (1-4or5+) na	1	ruck Driv	7e	Fur	niture	Store
DC.	in the King	BeC	17. Father's Name (First, Middle, Last)		18.	. Mother's Name (F	irst, Middle, Maide	n Sumame)	
ylaı		70 8	Wright Mayo			izzie C			
Mar	nd 2 sho ulth and 27 Is mu r trauma		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and			•	,
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic	1	Gladenia Swift-Niece 20a. Method of Disposition 20	b. Place of Dispos	nglish El	LM CE.,		Location - City or To	
m _o m	Pages nent of int: If Its iry or o		1 🔀 Burial 2 □ Cremation 3 □ Removal from State 1 ♣ 1 □ Donation 5 □ Other (Specify) □ (6		natory or other place) n Forest	1/13/	'06 Ov	nings Mi	lls, Md
Baltimore,	permit. Pages 1 and Department of Healinportant: If Item 2 any injury or other once.	Ì	21. Signature of Juneral Service Licensee	22.	Name and Address of arch F/H	f Facility			
8	20129		Mignettle to Jones	1 4	300 Wabas	sh Ave,	Baltimo	re, Md	21215
П			25a. Part 1. Enter the disease, or complications that caused the caused the cause of learn failure. List only one cause of leach line.		er the mode of dying, so	uch as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a con	_an Car					
	Examiner			isoquorico orj.					
1	₽ #a	iner	Sequentially list conditions, if any Leading to immunity cause. Enter Underlying Cause (Disease or injury	sequence of :					
V	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a con	sequence of):					
8760,	The law requires that the death cartificate be exaculed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai E	d						
9	tificate ng phy as the	0	V						
Вох	eath cartific attending p I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of prediction in the past 12 months?	Fetal death 3	Ectopic pregnancy			23d. Date of deliv Month	ery Day Year
о. В	at the dea by the ai	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	of death 5	Other (specify)			WORL	bay roan
<u>α</u>	that the post of t		Part II. Other significant conditions contributing to death but not	t resulting in the un	nderlying cause given in	n Part I.	23e. Did tobacco	use contribute to t	he cause of death?
rds	quires en sign	ed by					1 🗆 Yes	2 □ No 3 □ Prol	bably 4 Unknown
Records,	law requas been 2 shout	Completed					24a. Was an autopsy	 prior to co 	opsy findings available ompletion of cause of
<u>~</u>		Соп					performed 1 Yes 2 N	death?	21 No
Vital	Physiclan: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 12 No Hospital: 1 Inpatient	a∏50/0 · · · ·	Other	5. Place of Death (C			
of	g Phys er this eral dii	I=	27. Manuar of Death 28a. Date of Injury	2 ER/Outpatien	28c. Injury at	_	5 L. Hesidence I. Describe how in	6 ☐Other (Special ury occurred	у)
ion	Attending F or death. ector: After by the funer	atio	2 Accident investigation	ar) Injury	Work? M 1 ☐ Yes	2 🗆 No			
Division	f or Attence after death Director:	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (St.		eet, factory, office	28f	Location (Street City or Town, Sta	and Number or Run ite)	3/ Route Number,
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death	occurred at the time.	date and place, and	I due to the cause	s) and manner as s	stated
	n 24 h	edicai	(Check only 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or inv	estigation, in my opinio	on, death occurred	at the time, date a	nd place, and due t	o the cause(s)
	To the To the Comp		29b. Signature and title of certifier	1 M	29c. License nu	imber	29d. [ate signed (Month,	Day, Year)
•			P Meore C. Wills.	THE RIT	1 1941	560	40	nuary 1	2006
	3		29b. Signature and title of certifier Leona C. Wulls 30. Name and address of person who completed cause of death Seovae E. Wilks T. M.D.	(Item 23a) (Type, 3900 [Loch Rava	en Boule	vord, B	altimove	, MD. 21218
	Sta Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's S	ignature					

			1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artme rtifica	nt of H	ealth a	and M		giene ()	06	003	304
,	Physici	an	1. Decedent's Name (First, Middle, Last) Paul Nolan Myers,							Date of Dea Month	th Day	Year	3. Time o	
	/Medic	al	4a. Facility Name (If not institution, give			4h Cit	v Town or	Location of	of Death	01-	06 - 4c. County	06 of Death	11.4:	2 9 M
6.7	Examin	er	-	ospital Center	`		Osed					timor	70.	
100	Funeral		5. Social Security Number 6. Set		last birthday)	If Und	er 1 Year	If Under	Min	8. Date of Birth (Month, Day	Year)		lace (State	or Foreign
	Director		Usual Residence of Decedent	JM 2LIF /2	Yrs.					ec. 19	, 1933		land	
	/land		10a. State 10b. County	10c. Cit	y, Town or Lo	cation						1	Od. Inside C	City Limits
	a-fsh	ctor	Md. Harford		E	el A	ir						1 🗌 Yes	s 2 🔯 No
	or 28	Dire	10e. Street and Number			10f. 2	ip Code				10g. Citizen of		ntry?	
	sath v	erai	601 Flintlock Dri	.Ve 12. Was Decedent Ever in U	S 13	Was De		LO15	gin? (Spe	cify Yes or No-	U.S.A	ce - Americ	an Indian	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Hem 27 is marked other than "natural", or Hems 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1		2 No	Specify:	, Puerto f	cify Yes or No- Rican, etc.)	Bla	ck, White, y:whit	etc.	
Maryland 21215-0036	within 72 hou ene. than "natura i.e Medical E	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece (Give iife.	kind of 1	sual Occupa vork done d use retired	during most	t of workii	ng	16b. Kind of B	lusiness/In	dustry	
21	e filed within al Hygiene. i other than '	Сош		3	comp	ute	ana				inform		syst	ems
und	be file	Be	17. Father's Name (First, Middle, Last)							(First, Middle, Louise				
IT YE	2 should be and Mental is marked is raumatic ev	은	Irvin Myers 19a. Informant's Name/Relationship (Ty	rpe. Print)	19b. Mailii	na Addre	ss (Street a			/ Route Numbe			Code)	
	1 and 2 s Health ar Iem 27 is other trau		Margaret Myers/wi			•	,			Bel Air			-,	
Baltimore,	Pages 1 a lent of Hei nt: If Item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ © There (Specify)	Removal from State	Place of Disponentery, created Air	natory o	r other plac			ate /2006	20c. Location Bel Ai			
Balti	permit. Pages 'Department of H Important: If the any injury or of		21. Signature Aurieral 5 Licens			Sch:	and Addres Lmunel	s of Facilit		Home o				
8760,	Department of the property of	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consect of Due to (or a) Due to (or	uence of).	€31	pha	ge al	Car	neer			Interval Be Onset and	
P.O. Box 68		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	Ideath 3	⊒Ectopic ⊒ Other	pregnancy (specify)					ate of delive	ery Day	Year
	9 P 9	þ	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlyin	g cause give	en in Part I.			bacco use con es 2 🗆 No	tribute to the		death?
of Vital Records,	0 4 0	Completed								24a. Was autop	med?/	Were auto prior to co death? 1 \(\sum \text{Yes} \)	psy findings mpletion of	s available cause of
ita	sicien: Th certificete irector, pag	Be	25. Was case referred to medical examiner?						of Death	(Check only o	ne)			
	Phys r this ral dii	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Unpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injun Worl	4 🗆 190	2	ne 5 Resid 28d. Describe h			(y)	
Division	al or Attandi s after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st	reet, fact	ory, office		2	28f. Location (S City or Tow		ber or Rura	al Route Nur	mber,
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: Afte completely filled in by the fune	edical C	29a. Certifier 1 Certifying Phy (Chack only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurr vestigati	ed at the tin on, in my o	ne, date an pinion, dea	d place, a	and due to the dead at the time, d	ause(s) and m date and place,	anner as s and due to	tated. the cause((s)
	To the l within 2 To the complet	Me	29b. Signature and title of certifier				9c. License				29d. Date signe	,		
	7		1					1612			1/6/2			
	Sta Regist		30. Name and address of person who con Dr. Mohallad (31. Date filed (Month, Day, Year)	ompleted cause of death (Iter Habrash 10 38 Registrar's Sign	n 23a) (Type,	Print)	n S	quare	Driv	e Bal	limore,	HdZ	1237	7

			For State Registrar	State of Maryland		rtment of H			ene g. No. 006	00305
	Physicia	an	Decedent's Name (First, Middle, Last)		-			2. Date of Death Month		3. Time of Death
5	/Medic Examin	10	Betty Lynn 4a. Facility Name (If not institution, give s	Myers treet and number)	, ,	4b. City, Town, o	r Location of Death	· anuar	4c. County of Deat) 10',00
,	Funeral		Franklin Square 5. Social Security Number 6. Sex		enter	If Under 1 Year	SECOLE II Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Salt Year	hplace (State or Foreign untry)
	Director		212-34-5993	M 2DXF 69	Yrs.	Months Days	Hours Min.	6/8/19	36 Ma:	cyland
	death with the Maryland ma 23a or 28a-f show	7	10a. State 10b. County		, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2X No
	th the Nor 28a-f	Directo	Maryland Baltimore 10e. Street and Number	e Ess	sex	10f. Zip Code		10	g. Citizen of What Co	untry?
	na 23a	Funeral D	1507 Hopewell Avenu	12. Was Decedent Ever in U.S	S. 13. V	21221 Vas Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	J. S. A. 14. Race - Ame	
	within 72 hours after death with the Marylan piene. "Ithen "natural", or Itsma 23a or 28a-f show Itse Medical Examinar matike notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ XNo II Yes, Give Year or Dates:		Yes, specify Cuba	an, Mexican, Puerto Specity:	Rican, etc.)	Black, Whit	
315-UU36	within 72 hours after ene. then "naturel", or Its re Medical Examina		15. Decedent's Edu (Specify only highest grade	cation	(Give	lent's Usual Occup kind of work done	during most of work	ing 1	16b. Kind of Business	nite Industry
1212	I within piene. r then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Assemb	OO NOT use retired	1)		Phone Com	oany
land	be filed that Hyg d other svent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			
Maryla	should and Men a marke umatic	2	Milton Knapp 19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street	Etta and Number or Run	Marie al Route Number,	Thomas City or Town, State,	Zip Code)
	s 1 and 2 should if Health and Mer itsm 27 Is marke other traumatic		John L. Thomas (S	on-in-Law)		Prescott			Grace, MD	
Baltimore,	0 0		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	emoval nom State		sition (Name of natory or other plan Crematory	! !/:	9	Baltimore,	
Balt	permit. Pag Department Importent: I any Injury o		21. Signature of Funeral Service Licens		22 B1	. Name and Addre		L Home PA	A ssex, Mary	land 21221
-147			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death re cause on each line.	n. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in dealh)	Due to (or as a consequ		Isch	em ia			
	Examiner	١,	Sequentially list conditions, if any, leading to immediate	Due to (or as consequ		e dis	tress			
	cuted nd ranslt	Examiner	Cause (Disease or injury that initiated events	Vomitir	19	aspira	ation			
8760,	cate be executed oblysicien and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequ	ne(cel ol):					
x 68	entificate ding physice as the	Medic	IF FEMALE:	23c. If yes, outcome of pregna						
.О. Вох	that the death certific ned by the attending p detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify) _	у		23d. Date of de Month	Day Year
rds, P.	w requires that s been signed b should be deta	5	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did tob	pacco use contribute t es 2 No 3 □ P	o the cause of death?
Division of Vital Records,		Completed						24a. Was a autops perform	y prior to death?	utopsy lindings available completion of cause of
Vita	Physician: The la ir this certificete has aral director, page 2	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 🛣	ER/Outpatier	nt 3□ DOA Ot	nor	th Check only on	el ence 6 □Other (Spe	
ion of	nding Phy ath. r: After this e funeral d	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Inju Wo			ow injury occurred	Luy)
Divis	Hospitel or Attend 24 hours efter death Funerel Director: , iely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, larm, str	reet, factory, office		281. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospitel or Attending I within 24 hours effer death. To the Funerel Director: Affer completely filled in by the funer	edical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the to vestigation, in my	ime, date and place, opinion, death occur	, and due to the carred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	10)		29c. Licen	se number	2	9d. Date signed (Mon	th, Day, Year)
,			30. Name and address of person who o	ompleted cause of death (Item	n 23a) (Type,	Print)	0 0		/- /-	- 6
i			Dr. Diana Pana 31. Date liled (Month, Day, Year)	4 9000 Fr	anhli	in Squ	gre Drin	ie Bal-	timore, n	10 21737
	St Regist	ate trar	JAN 1 0 2006	82. Registrar's Signa	1	A STATE OF THE STA				

State of Maryland / Department of Health and Mental Hygiene 0 06 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MABELLE SYMINGTON MOORE JANUARY 8, 2006 11:45p^M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner COLLEGE MANOR LUTHERVILLE BALTIMORE | Hunder 1 Year | If Under 24 Hrs. 8. Date of Birth | 9. Birthplace (State or Form Months | Days | Hours | Min | APRIL 25, 191 | 1 | NEW YORK 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□M 2□XF Months 215-28-6400 94 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County or 28e-f ehow in then "naturel", or iteme 23s or 28s-f showing the Medical Exeminer must be notified at GULF STREAM 1 XYes 2 □ No FLORIDA PALM BEACH Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2727 NORTH OCEAN BLVD 33483 permit. Peges 1 and 2 should be filed within 72 hours after death v Depertment of Health and Mental Hygiene. Insportent: If Item 27 is marked other than "naturel", or Iteme 23a app. injury or other traumatic avent, the Madical Exemples. 2008. USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 21215-0036 1 ☐ Yes 2X No Specify: WHITE 3 N Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) MOSES SYMINGTON FLORENCE KOBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE BANKS daughter 1414 LOCUST AVE. BALTIMORE, MD 21204 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DRUID RIDGE 1/ 11/2006 PIKESVILLE, MD 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 21. Signature of F neral Service Licensee 16924 YORK RD. MONKTON, MD 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HUST Physician estive ees /Medical Due to (or as a consequence of) **Examiner** cardiomyopat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year Day 4□Pregnant at time of death 5 Other (specify) P.O. I been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 No 1 ☐ Yes 2 No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 urrsing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No (his 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Man or of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funerel Director: A completely filled in by the fi 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number leted cause of death (Item 23a) (Type, Print) Mi 0 Iliam Connell 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

DHMH 17 Rev 1/2001

ORIGINAL

			Please	State of Maryland				•		egible.	
		•	1 - State Registrar	State of Maryland			of Death		leg. No.	006	00307
	Discosta)		1. Decedent's Name (First, Middle, Las					2. Date of Dea	ith	Year	3. Time of Death
N. A. S. S. S. S. S. S. S. S. S. S. S. S. S.	Physici /Medio		DONALD BYRD	MARSTON, S	sr.			JANUME	19	2006	5:55 A M
	Examir	er	4a. Facility Name (If not institution, give Strail Hospital	6 0 1.	2		m, or Location of Death		4c. 0	County of Deat	1
- 1 ₂ \$2	Funeral Director		5. Social Security Number 6. Sec. 228 26 7181 11	x M 2□F 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Y Months Da	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day FCB 2	. Year)	9. Birt Co	hplace (State or Foreign untry)
	yland 10W		10a. State 10b. County	10c. City, 1	Town or Lo	ocation					10d. Inside City Limits
	Ba-fet	Director	mo Howa	no sy	KES	VILLE					1 Yes 2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-f ehow or other traumatic event, the Modical Examinar must be notified at	al Dire	10e. Street and Number 12571 Fwo	ian Hill Dr	ive	10f. Zip Cod	21784		10g. Citiz	en of What Co	
	er dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- Rican, etc.)	1-	4. Race - Ame Black, White	
36	irs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	12 Tes 2 No 1944 If Yes, Give Year or Dates: 1946		1 □ Yes 2 %	No Specify:			Specify:	HITE
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altin	permit. Page Department (Important: If any Injury or once.		21. Signature of Funeral Service Licen.		1/2 7/10	2. Name and A	Garner 1/12 ddress of Facility				-
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	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, deat n and/or in	h occurred at the	ne time, date and place my opinion, death occu	, and due to the or rred at the time, o	ause(s) a	and manner as place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	anoThom NO			cense number			signed (Mont	
			1 Janjan Kal	manather MD		R	ES-000		Jan	MR49	2006
	UX!		30. Name and address of person who	completed cause of death (Item 2	За) (Туре,	Print)	HOSPITAL	OF BAT	nn	one	
	St	ate	31. Date filed (Month, Day, Yéar)	32. Registrar's Signatur	re	2(100)2	\$7 ×				
	Regist	rar	JAN 1 0 2	nne been	k 1	lack .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 7:31 A.M January 08, 2006 Lottie Mae Ward Fritz Matlak 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Ellicott City
If Under 1 Year If Under 24 Hrs. Abundant Life 9950 Oaklea Court Howard 8. Date of Birth (Month, Day, Y June 16, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Year) 914 Days Hours 212-01-2913 91 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No **Maryland** Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9950 Oak Lea Court 21042 United States of America Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: White 1 Yes 2 No 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Raymond Valentine Margurite Schafer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Daughter) 8107 Ventnor Drive, Pasadena, Maryland 21122 Patricia A. Cave 20a. Method of Disposition

1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Lorraine Park Cemetery 01/12/06 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Ligensee Kollner Moo 333 8728 Liberty Road, Randallstown, Maryland 21133 23a. Fant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterioscherché 41 resulting in death) Due to (or as a consequence of) entla Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknowin 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 0 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence &XXOther (Specify) Living Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner The law requires that the death certificate be executed buriel-transil Box 68760, as the use ō detached P.0. signed I Records. been

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28e-f ehov any njury or other traumatic event. The Medical Examination and item page.

Baltimore, Maryland 21215-0036

Examiner Completed by Physician/Medical page 2 diter Hospital or Attending death y the Director within 24 hours after d To the Funeral Dir cl completely filled in y

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2

Certification:

4 Homicide

31. Date filed (Month, Day, Year)

29a, Certifier (Check only one)

of Vital

Division

To the

State Registrar

29b. Signature and tale of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert

While 32. Registrar's Signature

and manner stated.

TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

036246

29d. Date signed (Month, Day, Year)

115 Roesler Rd Glen Barnie MD 21060

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 🖔 00309 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer **Physician** Kathleen A. McMurtagh January 6, A^{M} 2006 7:03 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Hospice Casey House Montgomery Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 31, 1921 Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗓 F Yrs. 179-16-1064 84 Director Usual Residence of Decedent with the Maryland 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or terme 23a or 28e-f ahov the Medical Examiner must be notitled at 1 ☐ Yes 2 No Maryland Montgomery Bethesda Direct 10e. Streel and Number 10f. Zip Code 10g. Citizen of What Country? 10301 Grosvenor Place, #1712 20852 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. l □Yes 2X No fYes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: ģ White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Executive Secretary marked other 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Pages 1 and 2 should be file frient of Health and Mental Hi tant: If them 27 is marked oth jury or other treumatic even Be Thomas Carroll 2 Mary Lyons t9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. McMurtagh/Husband 10301 Grosvenor Place, #1712, N. Bethesda, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate permit. Pages
Depertment of h
Important: If its
eny injury or of January 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 13, 2006 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signatura of Funeral Service Licensee M013057557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Recurrent Pneumonia **Physician** /Medical Due to (or as a consequence of) Examiner Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine signed by the ettending physicien and d be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death bull not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performed? page this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No or Attending Physician: ector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospice 1 ☐ Yes 2 No ŧ 2 1 Inpatient 2 ER/Outpatient 3 DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending М investigation 1 ☐ Yes 2 ☐ No the Director 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours e To the Funeral the Hospital 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) January 6, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 1 0 2006

			For State Registrar	State of Maryla		artment of H tificate of L		Ť	giene Reg. No.	00310
~	Physici		1. Decedent's Name (First, Middle, Last) Sakhawat	rai M. Och	nanev			2. Date of De Month	Day Vo	
	/Medio Examin		4a. Facility Name (If not institution, give s BALTIMORE WASKING	treet and number)		4b. City, Town, or	Location of Dea		4c. County of D	eath ARWOEL
۲,	Funeral Director		Social Security Number 6. Sex	7. Age (In yı	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of Birt	y, Year)	Birthplace (State or Foreign Country) Pakistan
	Maryland a-f ehow	stor	Usual Residence of Decedent 10a. State 10b. County Maryland Howard	10c.	City, Town or Lo	cation Fulto	on			10d. Inside City Limits 1 □ Yes 2X No
	th with the 23a or 28 let be no	ai Director	10e. Street and Number 11600 Mirror Pond	Court		10f. Zip Code	759		10g. Citizen of What USA	Country?
920	within 72 hours after death with the Maryland ane. then "naturel", or iteme 23a or 28a-f ehow (a Masiral Exhibiter matal be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi fYes, specify Cuba 1 □ Yes 2X No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No arto Rican, etc.)	Black, W	merican Indian, Inite, etc. Sian Indian
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	Sta Regist	ate rar	31. Date (Jan (Mogh, Day, Year)	32. Registrar's Signature	gnatue	9				

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X Q Q	w requires that the death certif been signed by the attending should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	h 2 Fet	al death 3□	Ectopic pregnancy Other (specify)			23	3d. Date of del Month	Day Year
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<u>,</u>	law requires that the as been signed by th 2 should be detache	by Pi	Part II. Other significant conditi	ons contributing to dea	th but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use	e contribute to	the cause of death?
cords	en sig		END STAGE RENA	L DISEASE					_ 1□	Yes 2	No 3□Pr	robably 4 Unknown
ပ္ပ	faw re las be	Completed							24a. Wa	s an	prior to	utopsy findings available completion of cause of
<u>~</u>	sicien: The faw certificate has birector, page 2 s	Con							peri 1 ☐ Yes	ormed? 2 No	death? 1 🗌 Yes	* 4
VIIal	sicien: certific irector,	Be	25. Was case referred to medica examiner?	Hospital: 8			Othic	00	Death (Check only			
ō	> 0 0	To To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of (Month)		ER/Outpatier 28b. Time of	it 3L DOA	4 🔲 Nursing	g Home 5 Res			cify)
UIVISION	nding Ith. r: Afte e func	atlor	1 Natural 5 Pendir 2 Accident investi	.9	Day Year)	Injury		k? Yes 2 □ No				
<u>≥</u>	er des rector by th	Certification:	3 Suicide 6 Could 4 Homicide determ	sined 200. Flace U	f Injury - At I	nome, farm, str	eet, factory, office		28f. Location City or To	(Street and own, State)	Number or Ri	ural Route Number,
5	itel or irs afti ral Di lled in											
	Hosp 24 hou Funa stely fil	Medical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	ng Physician: To the b Examiner: On the bas and manne	is of examin	owledge, deatl ation and/or in	occurred at the time vestigation, in my of	ne, date and pla pinion, death o	ace, and due to the ccurred at the time	e cause(s) a , date and p	ind manner as place, and due	s stated. a to the cause(s)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certific				29c. License	e number		29d. Date	signed (Mont	th, Day, Year)
			1	Kyos			D 37	254		1/4	4/06	S
	\ 6		30. Name and address of person	who completed cause	of death (Ite	m 23a) (Type,				*		
	9		31. Date filed (Month, Day, Year,	M. D. 7641	OSL	ER DRI	VE TOWS	ON MAI	RYLAND (21204		
	Sta Registi		31. Date filed (Month, Day, Year, JAN 1	0 2006	gistrar's Sign	ature	ne de					
-	3.	-4 2		1	- ·	0						

				State		Department of Certificate	of Health and I		ZUUb	00312
				1. Decedent's Name (First, Middle, Last)		Certificate	OI Beatin	2. Date of Death		3. Time of Death
		Physici		RUSSELL		PITT	3	Month	Day 260	1 61111 111
		/Medic Examir		4a. Facility Name (If not institution, give street and number	r)	4b. City, To	wn, or Location of Death	1	4c. County of De	
				GILCHRIST HOSF	ICE		TOWSO		BA	LTIHORE
		Funeral		5. Social Security Number 6. Sex 7. A	Age (In yrs. last birt	thday) If Under 1 Months C		8. Date of Birth (Month, Day,	Year) 9. B	inhplace (State or Foreign Country)
		Director		Usual Residence of Decedent	/ 9	YTS.		APRIL 3	1426 NO	RTH CAROLINA
		land ow		10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
		death with the Maryland ms 23s or 28s-f show	ţŏ	MARVLAND N/A		1	ALTIMO	ORE C	TU	18€Yes 2 No
1		or 28s	Funeral Director	10e. Street and Number	10	10f. Zip Co			g. Citizen of What C	Country?
t h		23a	ia L	1712 EAST 32"	STREE	=T	2121	18	U	5A.
7		ltems Der me	rue	11. Marital Status 12. Was Deceden Armed Forces	it Ever in U.S.	13. Was Deceder If Yes, specify	nt of Hispanic Origin? (Se Cuban, Mexican, Puert	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
10	36	s afte	by Fu	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ 3 □ Widowed 4 □ Divorced Yes, Give Yes, Give		1 ☐ Yes 2/2	P		Specify:	2 + + 2 1/
7	5-003	within 72 hours after 6ne. than "natural", or Ite	edt	3 Widowed 4 Divorced Year or Dates 15. Decedent's Education		Decedent's Usual (Occupation	-	6b. Kind of Busines	CACK
0	215	nin 72 n "ne	piet	(Specify only highest grade completed)		(Give kind of work of life. DO NOT use	done during most of wor.	king	ob. Italia of Dasilles	amoustry
	212	e filed withing the Hygiene. other then	Completed	Elementary/Secondary (0-12) College (1-4or	3+)	STEEL	WORKER	2	BETHLEA	HEM STEEL
dy.		buld be filed Mental Hygid arked other atic event, I	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, M	laiden Surname)	
2	Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryls Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f shouten 27 is marked other than "natural", or Items is confiled at	2	HENRY	PITTS	5R.	MAN	IE	Co	FIELD
.0.	Nar	and raum	1	19a. Informant's Name/ Flationship (Type, Print)	19b.	. Mailing Address (S	Street and Number or Ru		,	Zip Code)
3	e,	s 1 and if Health Item 27 other tr		CLEMENTINE PITTS (U	20h Place of	Disposition (Name	32 NAST	. BAL	TIMORE	MO21218
1	סר	if It		1 Burial 2 Cremation 3 Removal from State	e cemeter	ry, crematory or other	ar place)	2	oc. Location - City o	r Town, State
000	듩	permit. Pages Department of Important: If II any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Life See	_ GARR	2150N FO,	REST 01-1	1-06 6)WINGS	YILLS, MA.
7	Ba	permit. Departr Imports any inj			m	JUSE	Address of Facility	BROWN	JK, FUN	ERAL HOME
				23a. Part1. Enter the disease, or complications that cause	ed the death. Do r	not enter the mode of	of dying, such as cardiac	or respiratory arre	1 1014C10	Approximate
- 1		Physician		snock, or near failure. List only one cause on each	ine.					Interval Between Onset and Death
8	130	/Medical		disease or condition resulting in death) a. Due to (or a	s a consequence	irng Co	ay (er			Years
y		Examiner		Sequentially list conditions b		- ,.				
2		₽ .≅	ner		is a consequence .	of):				
Z.		ecute and I-trans	Examiner	that initiated events c.		. D				
0	760,	be executed ician and burial-transit		Due to (or a	s a consequence o	01):				
	387	8 × 6	dlcal	d		······································				
	0х 68	leath certifica ettending ph i for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant	e of pregnancy				23d. Date of de	livon.
10	B	setter of for u	clar	in the past 12 months?	2 Fetal death at time of death	3 ☐ Ectopic pregi 5 ☐ Other (speci			Month	Day Year
-	0	it the de by the tached	hysi	9 ☐ Unknown 9 ☐ Unknown						
,	ď.	res that igned t be det	by P	Part II. Other significant conditions contributing to death	but not resulting in	the underlying caus	se given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
1	ğ	w require been sig						1 ☐ Yes	2 □ No 3 □ F	robably 4 Onknown
	Record	has be	Completed					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
		The l	Son					perform 1 Yes 2	ed? death?	h
77	Vital	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?				th (Check only one		
In	of	S 50	မ	1 Yes 2 No Hospital: 1 Inpat		tpatient 3 DOA			nce 6 Other (Spe	ecity) Hospice
S		ding Ph h. After th funeral	on	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, D	ay Year) 286. I	Fime of 28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	v injury occurred	
S	Division	or Attendation death Director:	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Ir	niury - At home fa	rm, street, factory, o		28f Location (Stre	et and Number or F	Jural Poute Number
3	Ö	after after Dire	Certification:	4 Homicide determined building, s	etc. (Specify)	im, street, factory, o	anice .	City or Town,	State)	idiai nodie ivalibel,
0)		pspite hours meral y fille	ai C	29a. Certifier 1 Certifying Physician: To the bes	t of my knowledge	, death occurred at 1	the time, date and place,	and due to the car	use(s) and manner a	is stated.
		To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	edicai	(Check only 2 Medical Examiner: On the basis and manner s	of examination and	d/or invastigation, in	my opinion, death occur	red at the time, dat	e and place, and du	e to the cause(s)
_		With To t	Σ	29b. Signature and title of certifier			icense number		d. Date signed (Mon	
- 1	,	. 1 /		Yara (Stall 1	1 0		0061199		Ja4, 08.	2006
	2	+ Key		30. Name and address of person who completed cause of	death (Item 23a) ((Type, Print)	C+ T		1.1	2.04
		of a store	10				St, Tou	USU-7 /	40 21-	204
	- 24	Sta Registi		INV 1 0 2006	trar's Signature	grafe ?				

			For State Registrar	State of Maryland		artment of H		d Mental Hy	giene	'HHb	00313
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) CACACA 4a. Facility Name (If not institution, give s		Lisch	4b. City, Town, or	r Logation of D	2. Date of Do Month	Day	Year 2006	3. Time of Death
	Examir Funeral Director	er	3524 01118 6. Sex 314 40 3807	0 A 0 7. Age (In yrs. Ia.	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I		rth ay, Year)	9. Bir	thplace (State or Foreign
	he Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10c. County 10c. County	10c. City,	Town or Lo						10d. Inside City Limits 1 □ Yes 2★ No
	be tiled within 72 hours after death with the Maryland tila Hygiene. ad other then "naturel", or Items 23e or 28e-1 show event, the Medical Evarifrer nast by multibud at	Funeral Dire		2. Was Decedent Ever in U.S Armed Forces?	. 13.	10f. Zip Code AllS Was Decedent of H f Yes, specify Cuba	lispanic Origin? an, Mexican, Pi	(Specify Yes or Ni erto Rican, etc.)	1	14. Race - Ame Black, Whi	encan Indian,
15-0036	72 hours affe "naturel", or I	þ	1 Never Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade		16a. Dece	1 ☐ Yes 25 No dent's Usual Occup kind of work done	during most of	working	16b. K	Specify: W	STIFE
Maryland 21215-0036	be filed within fal Hygiene. d other then "event, the Me	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Acco	ONOT use retired	yable	nd Receivable Namo (First, Middle	a, Maiden	PHH Sumame)	
Maryla	d 2 should th and Mer 7 Is marke treumetic	Tol	19a. Informant's Name/Relationship (Tyx	De, Print)	19b. Mailir	ng Address (Street	and Number of	Rural Route Numb	Der, City o	or Town, State,	Zip Code) 21154
Baltimore,	Pages 1 nent of Hi ant: If iter ary or oth		20a. Method of Disposition Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	ice of Disponetery, crem	sition (Name of natory or other place	AR-	Date A 00b	20c. Lo	ocation - City or	ar Marilano
Bal	permit. Departr Importe eny Inji		21. Sun ture of Funeral Serve License 23a. Part1. Enter the disease, or complishock, or heart failure. List only on		Do not ent	er the mode of dyin	ss of Facility CCL Ig, such as care	fiac or respiratory a		MIT W	Approximate Interval Between
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co)sequ	perito	ned Car					Onset and Death 32 mes.
8760,	cate be execufed physician and if he burial-fransit	dical Examiner	Sequentially list conditions, if any, leading to immediate outs. Exact Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque							mey.
O. Box 6	death certifi e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25€ No 9 □ Unknown	ac. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetalic 4 □ Pregnant at time of dea 9 □ Unknown	leath 3□	Ectopic pregnancy	,			23d. Date of de Month	vivery Day Year
ords, P.	The law requires that the ste has been signed by the bage 2 should be defache	by	Part II. Other significant conditions con	tributing to death but not result	ting in the u	nderlying cause giv	en in Part I.				o the cause of death?
Vital Record		e Completed	25. Was case referred to medical				26 Place of	24a. Was auto perfi	psy ormed? 2000 No	prior to death?	utopsy findings available completion of cause of
of	ding Phys n. Affer fhis funeral di	ation: To B	examiner? 1 Yes \$\$\frac{25}{25}\$No H 27. Manner of Death 15\$\frac{1}{2}\$Natural 5 Pending investigation		R/Outpatier 28b. Time of Injury	28c. Injun Wor	er: 4 □ Nursin v at	g Home 5 Res 28d. Describe	idence		ecify)
Division	To the Hospitel or Attent within 24 hours after deaft To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)				City or To	wn, State	·)	ural Route Number,
	To the Hos within 24 ho To the Fun- completely (Medical	29a. Certifier (Check only one) Certifying Phys Certify	ician: To the best of my know er: On the basis of examination and manner stated.	on and/or in	vestigation, in my o	pinion, death o	ace, and due to the courred at the time,	date and	and manner as I place, and dur	e to the cause(s)
•	P 3 5 8	7	Michael McCille			D041					
1	2 '		30. Name and address of person who co	10 Collum	910:	Print) 3 Fran 1	(lin)	Square	Dr.	Baltima	1,2005 10,005
	Sta Regist		JAN 1 0 2006	32. Registrar's Signatu	Ire Cost	E. P		/			1

DHMH 17 Rev 1/2001

		•	. 101	partment of Health and Mental Herificate of Death	Hygiene 006 003	
	Physicia		1. Decedent's Name (First, Middle, Last) RICHARD HEBER PEMBROKE JR	2. Date of Month	Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	1
	Funeral		Simai Hospital of Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8. Date of	N/A f Birth 9. Birthplace (State or	Foreign
	Funeral Director		220-44-4502 1XX 2□ F 95 Yrs.	Months Days Hours Min. Novemb	g Birth 9. Birthplace (State or Country) Wer 27, 1910 West Virgin	
	yland sow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City	y Limits
	Be-f et	ctor	Maryland N/A Baltim		1 Yes	2 🗆 No
	with the	Funeral Directo	10e. Street and Number 15 Elmwood Road	10f. Zip Code 21210	10g. Citizen of What Country?	
	death	nera		Was Decedent of Hispanic Origin? (Specify Yes o. If Yes, specify Cuban, Mexican, Puerto Rican, etc.	r No- 14. Race - American Indian,	
30	rs after	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Wes 2 ☐ No WW II I IYes, Give Year or Dates:	1 ☐ Yes 2XXNo Specify:	Specify: White	
212-0030	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28e-f ehow he Wedteal Evantinar mast ter notified at	sted t	15. Decedent's Education 16a. De	cedent's Usual Occupation ive kind of work done during most of working	16b. Kind of Business/Industry	
7	withIn ane. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5+	e. DO NOT use retired) Psychoanalyst	Medical	
א שנ מ	filed Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mic		
yian		ToE	Richard Heber Pembroke	Ella Boggs		
Mar	12 7 Is		1 1 1 1	ailing Address <i>(Street and Number or Rural Route Nu</i> Binaco Road Epping New Ha		
e,	es 1 and 2 of Health If Item 27 or other tre		20a. Method of Disposition 20b. Place of Disposition	sposition (Name of Date prematory or other place)	20c. Location - City or Town, State	
Baltimore,	Pag ment ant:		*4 Donation 5 Other (Specify) GreenMou	int Cemetery 1/16/06	Baltimore, Marylar	
Ra	permit. Pag Department Importent: any injury o		21 Fignature of Funeral Service Licensee		-Wiedefeld Funeral Home In ad Baltimore, Maryland 212	
	s.*		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		ory arrest, Approximate Interval Betw	veen
	Pnysician /Medical	2 7	Immediate Cause (Final disease or condition resulting in death)		Onset and p 3 Week	eath
	Examiner		Due to for as a consequence of):	nerene - Left leg.	3 week	Y
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	It with Thompson	Soli events 3 week	
a a	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):	when was interrepoem	voluc evenis surege	<i>^</i>
8760	ate the	dical	d			
Box 6	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery	
	a death he atte	Completed by Physician/Med	in the past 12 months? 1 Yes 2 No 1 I Yes 2 No	3 □Ectopic pregnancy 5 □ Other (specify)	Month Day Y	ear
о. О	w requires that the de been signed by the s should be detached	/ Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e. I	Did tobacco use contribute to the cause of de	eath?
rds,	quires an sign uld be	ed b)	Conjective Heart failure		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 🖰	nknown
eco	has bee	npiet	U		Was an autopsy findings a prior to completion of ca	variable luse of
Division of Vital Records,	ician: The certificate h rector, page	e Con	OF Was ages referred to modical	1 □ Y		
Z Z	ysicia is certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No Hospital: 1 ▼Inpatient 2 ☐ ER/Outpa	26. Place of Death (Check of tient 3 DOA Other: 4 Nursing Home 5 I	Residence 6 Other (Specify)	
o uc	ling Ph n. After th funeral		27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury Injury (Month, Day Year)		ribe how injury occurred	
Visio	l or Attending Phys after death. Director: After this in by the funeral di	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office 28f. Locati	ion (Street and Number or Rural Route Numb or Town, State)	ber,
ā	ital or irs afte ral Dir		(<u> </u>	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d (Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, and due to r investigation, in my opinion, death occurred at the ti	o the cause(s) and manner as stated. cime, date and place, and due to the cause(s)	
	To th withir To th	M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
)			Moush A.V. 30. Name and address of person who completed cause of death (Item 23a) (Ty	RES-000	JANUARY 4,2006	
	10		MANISH ARORA, MD. 2401 W.	RELYEDERE AVE, BALT	TIMORE, MD.	
	Sta Regist		31. Date filed (Month, Day, Year) JAN 1 0 2006 32 Registrar's Signature			

L PEMBROKE, KICHARD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.0.

				rtificate of Death	Reg. P		00315
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Geraldine Louise Plowman 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	January 4	, 2006 4c. County of Death	J T M
	Examin	er	1213 W. 40th Street	Baltimore		N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)			-	place (State or Foreign
	Director		212-34-9574 1□M 2ᡚ\$ 68 Yrs.	Months Days Hours Mill	Nov. 2, 1		Virginia
	and	}	Usual Residence of Decedent 10c. City, Town or I 10a. State 10b. County 10c. City, Town or I	ocation			Od. Inside City Limits
	Maryl	Į.	Maryland N/A	Baltimore	9		XXYes 2 □ No
	r 28a	lrec	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Cour	ntry?
	th with	Funeral Director	1213 W. 40th Street	21211		USA	
	r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
S	s afte	by Fi	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 202 No Specify:			white
3-003e	2 hours			dent's Usual Occupation	16b.	Kind of Business/In	dustry
2	hin 72	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation a kind of work done during most of wa DO NOT use retired)	rking		,
7 7	ed wit	Con	12 De	sktop Publishing	J	ohns Hopk	ins
/iand	be file	Be	17. Father's Name (First, Middle, Last) Russell Selvey		me <i>(First, Middl</i> e, <i>Maid</i> s Simmons	en Sumame)	
Ž	d Mer narke natic	2				T 0 T	0.11
Ma	than than traur			ing Address <i>(Street and Number or R</i> 7 East Greenbank		imore, MD	
ē,	f Heal		20a. Method of Disposition 20b. Place of Disp	osition (Name of matory or other place)	STATE OF THE PARTY	Location - City or To	
Ē	Page: ient o nt: If ry or			ematory 1/6/	'06 Ca	tonsville	, Maryland
saitimore,	permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at once.		21. Signatur of uneral Service licenses	2. Name and Address of Facility ourgee—Henss—Seitz 631 Falls Road			
	70 = e o	-	Jan Supuli	631 Falls Road B	altimore,	Maryland 2	
			23a Parti. Exter the disease, or complications that caused the death. Do not exchock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. CARO/Id 5	Tenosis			
	Examiner		(or as a consequence on):	ACTOR dies	OACH		
F		ner	Sequentially list conditions, Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Charles Conditions, Dual to (or an a nonneculance of) cause (Disease or injury that initiated events) c. 4145eTeS M	TENOSIS AFTERY DISE	7150		
*	scuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1 ellitus.			
oC,	tificate be executed g physician and as the burial-transit		resulting in death) Last Due to (or as a consequence of):				
08/0 0 ,	ficate phys s the	edical	d				
XOD	nding use a	-	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	эгу
Ď	death cer e attendir id for use	Physician/N	in the past 12 months? 1 Ves 2 TANO 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
5	at the by the staches	hys	9 Unknown				
Š,	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	þ	Part II. Dther significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.		o use contribute to the	
coras	requii	eted			1 Tes	2 Mo 3 Prob	ably 4 Unknown
ဒ္	2 2 2	Completed			24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of
<u> </u>	siclan: The law certificate has t irector, page 2 s				1 ☐ Yes 2√21		2 No
VII	Physician; this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Othor	ath (Check only one) Home 5 Residence	2 Flore / 2 /	
ō	ding Physician; The In. h. After this certificate he funeral director, page	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how in		/)
VISION	andin ath. or: Aft	atlo	1 Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
<u> </u>	or Atterde	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta		I Route Number,
ב	pital ours at eral D	O	200 Codifier 1 Codificing Physician To the heat of my leasurates described			()	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, dea 2 ☐ Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place expecting tion, in my opinion, death occurred.	e, and due to the cause urred at the time, date a	(s) and manner as si ind place, and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month,	Day, Year)
			La Celler Co	D44271		1/6/06	7
	10		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	1 210	92	
	Sta	te	31. Date filed (Month, Day, Year) 32. Ratistrar's Signature	TOUND IN	0-7	10	
	Registr		JAN 1 0 2006	Accept 6			

06-0073 Unpend item#234,27, pent in Black Indelible Ink. Ensure All Copies Are Legible. B.K.S GARY WAYNE PETERSON State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** Gary Wayne Peterson JAN 2006 0923 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1032 Downton Road ARBUTUS BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/06/54 9. Birthplace (State or Foreign Country)
Balto., MD 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 1 M 2 ☐ F **Funeral** Director 216-60-5733 51 Usual Residence of Deceden Manyland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-1 ehow Examiner must be notified at YYes 2 No Director Arbutus MD Baltimore Co. the 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? ö items 23a 21227 USA 1032 Downton Road death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Asped Forces?
1 ∱1Yes 2 □ No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Specify: White Specify: Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Catonsville the Medical 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Community College of permit. Pages 1 and 2 should be filed to Depertment of Health and Mental Hygie important: if item 27 is marked other tileny for other fraumatic event. Its once. Civil Engineer Baltimore 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be June (Duffy) Peterson ျှ Arthur M. Peterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) June Peterson - Mother 1032 Downton Road, Arbutus, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Meadowridge Memorial 01/07/06 Elkridge, MD 21. Sign tute of Funeral Service 22. Name and Address of Facility Ambrose Funeral Home, 1328 Sulphur Spring Road, Arbutus, MD UM2 Inc 21227 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consumence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 △ Yes 2 □ No 24a Was an 2□ No 1⊠ Yes After this certific funeral director, 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) AT SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 1 Yes 2 □ No 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Yes 2 No death. investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 - Homicide filled in 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) within 2 To the 100 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ို

(b)

Registrar

ate 31. Date filed (Month, Day, Year) rar JAN 1 0 2006

30. Name and address of person who compt

O.C.M.E

JAN. 4, 2006

			For State	State of	Marylan		artmen			and Me		1	IIIII	00317
	n e	4	Registrar 1. Decedent's Name (First, Middle, Las	-t1		Cel	uncau	e or L	Jeani		2. Date of Dea	Reg. No.		2 Time of Death
	Physici	an			illett						Month January		2006 Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give			.е	4h Cihr	Town or	Location o		January			12:50 A ^M
	Examin	er			, et					n Death			County of Dea	
	5		Rockville Nursing 5. Social Security Number 6. S		Age (In yrs.	last birthday)	If Under	(vil]	If Under a	24 Hrs.	8 Date of Birt		ontgom	
	Funeral Director			™ 2□F	90	Yrs.			Hours	Min.	8. Date of Birt (Month, Da) December	(Year)	915 02	rthplace (State or Foreign Country) egon
			Usual Residence of Decedent								Decamber	-	713 01	CGOII
	ylan		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	B-1 s	ţċ	D.C.		Was	hingto	n							1X Yes 2 □ No
	or 28	lre	10e. Street and Number		•		10f. Zip	Code				10g. Citi	zen of What C	Country?
	th wi	ai	4915 Sedgwick St	reet, N.	W.		20	0016				Un	ited S	tates
	eme eme	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U. es?	.S. 13. \	Vas Deced	dent of Hi	spanic Orig	gin? (Spec	ofy Yes or No- lican, etc.)		14. Race - Am Black, Wh	
98	or It	J.	1 Never Married 2 Married	1 X Yes 2 If Yes, Give	□ No		1 ☐ Yes				,	- 1		White
ğ	within 72 hours after death with the Maryland ene. than "naturel", or tieme 23e or 28e-f show the Madical Exemples. Ask be mullified at	d by	3 ₩ Widowed 4 Divorced	Year or Date	es: WWII	1								
7	"nat	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	lent's Usua kind of woi DO NOT us	rk done d	luring most	of workin	g	16b. Kir	nd of Business	s/Industry
2	withiv Bne. than	mc	Elementary/Secondary (0-12)	College (1-4	or 5+)		es Ma					Oi	1 Compa	anv
9 9	filed Hygi ther ont.	ŏ	17. Father's Name (First, Middle, Last)							r's Name	(First, Middle,			
Maryland 21215-0036	d be antal	To Be	Webster Benedic	t Pillet	te					Hugh				
<u> </u>	shoul od Me mark masti	ř	19a. Informant's Name/Relationship (vpe, Print)		19b. Mailin	a Address	(Street a			Route Numbe	r. City or	Town State	Zin Code)
\mathbf{z}	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show stay fulrry or other treumatic avent, the Mudical Examinate stables notified at ODGs.		Rondi K. Pillett	_	er	4915								D.C. 20016
Baltimore,	Hear Hear tem		20a. Method of Disposition			lace of Dispo			T	Da	ite		cation - City o	
5	ages ant of tr. If i		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5)		ale	emetery, cren Egomery			1 -	anuai 200		P 0 +1	hoodo	Marriland
	ertme ortar injur	1	21. Signature of Funeral Service Licen		rion									Maryland
ä	Depermitmbo		William a. Pur	shier.	M0117	3 300	pert A	Monto	mphrey omerv	Avenue	ral Home	Ro	ckville,	Inc. nd 20850
У			23a. Part1. Enter the disease, or comp	nications that cau	sed the death								raryra	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final			D								Interval Between Onset and Death
Post.	/Medical		disease or condition resulting in death)	a	as a consequ	Pneumo	nia							-
	Examiner			Parki	,	Diseas	ρ							
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		de di consequ									
1	outed d ansit	Examiner	Cause (Disease or injury that initiated events	Demen	tia									
o,	an ar		resulting in death) Last	Due to (or	as a consequ	uence of):								
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical		d. Sersi	s									
9	ng ph	Ned	IF FEMALE:									- 1		
Вох	th ce tendi	an/	23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Ectopic pro	egnancy				2	3d. Date of de	
Э.	e dea he at led fo	sici	in the past 12 months? 1 Yes 2 No		nt at time of de		Other (sp						Month	Day Year
P.O.	at the	Phy	9 Unknown								T			
s,	w requires that the death certific been signed by the atlending p should be detached for use as	ρ	Part II. Other significant conditions of	onthouting to dear	th but not rest	ulting in the ur	nderlying ca	ause give	in in Part I.					to the cause of death?
oro	neau s	ted									104	es 2 L	JNo 3∐P	robably 4 X Unknown
e	law lasb	nple									24a. Was a	Sγ	24b. Were a	utopsy findings available completion of cause of
Division of Vital Records,	The cate h	Completed									perfor	med? 2 No	death?	
ita	Attending Physician: or death. sctor: After this certifica by the funeral director, g	Be	25. Was case referred to medical examiner?							of Death	(Check only o	7e)		
<u>}</u>	hysi this o	ဥ	1 ☐ Yes 2X No			ER/Outpatien			4 K7 1401		e 5 Resid			ecify)
E C	ing F	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month,	Day Year)	28b. Time of Injury		8c. Injury Work			3d. Describe h	ow injury	occurred	
Sic	ttend death death tor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be				М		res 2□N		26 1 27			
<u>≥</u>	or A	rtif	4 Homicide determined	28e. Place of	I Injury - At ho , etc. <i>(Specif</i>)	ome, farm, str v)	eet, factory	, office		28	City or Tow	treet and n, State)	d Number or A	lural Route Number,
	pitel ours a eral I		29a. Certifier 1X Certifying Ph	voicion. To the b										
	Hos 24 hc Fun stely	edical	29a. Certifier (Check only one) 1X Certifying Ph 2 Medical Exam	iner: On the bas and manne	is of examinal	wiedge, death tion and/or inv	estigation,	at the tim in my op	e, date and inion, deat	n piace, ar h occurred	d at the time, o	ause(s)	and manner a place, and du	s stated. e to the cause(s)
	To the Hospitel or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2	Mec	29b. Signature and title of certifier	and manne	stateu.		29c	. License	number		:	29d. Date	signed (Mon	th, Day, Year)
	F ≯ F ŏ			V. 1	osent	1			7330				ary 6,	
,	. 1		Mom and address of person who										-, -,	
	67		30. Name and address of person who a Thomas V. Joseph				,	rivo	#207	7. P.	ckville	a. Mī	2085	52
110	Sta	te	31. Date filed (Month, Day, Year)	₽2. Rec	istrar's Signa	ture		TIVE	. ,, 207	, 10	CVATTTE	, ril	200	<i>,</i>
	Registr		JAN 1 0 2006	Alex	a A	Spece	K							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Cortificate of Death

		1 - For State Registrar	State of M	aryland /		rtment tificate				jiene leg. No.	006	00318		
Dhyais	ion	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	ith Day	Year	3. Time of Death		
Physic /Med		EDWARD A. PACK							JANUARY	77,	2006	5:30 Ам		
Exami	ner	4a. Facility Name (If not institution, give						cation of Death			ounty of Death			
-		VA MARYLAND HEALTH 5. Social Security Number 6. Se		STEM je (In yrs. last	birthday)	If Under 1	Year If	Under 24 Hrs.	8. Date of Birtl		CECIL 9. Birth	place (State or Foreign		
Funeral Director]M 2□F	82	Yrs.			lours Min.	(Month, Day 7-16-)	923		RGINIA		
P .		Usual Residence of Decedent												
arylar show	7	10a. State 10b. County		10c. City, To		ation						10d. Inside City Limits 1, Yes 2 No		
Media 28a-f	ecto	MD • HARFORD 10e. Street and Number		ARIN	IGDON	10f, Zip C	ado.			10a Citina	n of What Cou	21		
aa or	Funeral Director	1400 HILSCHER CT	•				009			_	SA	andy:		
death ms 23	nera	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W	Vas Deceder	nt of Hispa	nic Origin? (Spe	cify Yes or No-		. Race - Amer			
or Ita		1 Never Married 2 Married	Armed Forces? 1 ☑¥es 2 ☐ If Yes, Give		}	Tes, specify ☐ Yes 2		Mexican, Puerto	rican, etc.)		Black, White			
hours ural',	Completed by	3X Widowed 4 □ Divorced	Year or Dates:		1					1	DLA			
in 72 "nat	olete	15. Decedent's Edu (Specify only highest grad	e completed)		(Give k	ent's Usual (kind of work O NOT use	done durii	n ng most of worki	ing	16b, Kind	of Business/li	ndustry		
d with jiene. r thar	E	Elementary/Secondary (0-12) -12-	College (1-4or -0-	5+)	STORE	E OWNE	R				GROCERY	Z		
al Hyginothe	BeC	17. Father's Name (First, Middle, Last)					18	. Mother's Name	•		umame)			
ould b Ment arkac	To I	ARCHIE PACK							E FLEMIN					
and rand		19a. Informant's Name/Relationship (T)		1				Number or Rura						
1 and Health am 27 thar t		YASMIN CARROLL (D	AUGHTER)	20b. Place		O HILS sition (Name		CT. AB	INGDON,_		LAND 2			
ages int of t: If it		1 XBurial 2 Cremation 3 F 4 Donation 5 Other (Specify)		ceme	etery, crem	atory or oth	er place)	!				LLS, MARYLAN		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, the Maryland Examination untilled at once.		21. Signature Funer Service Licens						of FacilityPHII						
Depar Impor		Joseph (). Aug	sien)								LAND 21217		
		23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.												
Physician		Immediate Cause (Final disease or condition	CONGE	STIVE H	HEART	FAILU	IRE					Onset and Death UNKNOWN		
/Medical		resulting in death)	Due to (or as	a consequen	nce of):									
		Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequen	nce of):									
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	c.											
an an rrial-tr		resulting in death) Last		a consequen	nce of):									
icate be executed physician and the burial-transit	dlcal	•	d											
entific ding p se as	(0)	IF FEMALE:	23c. If yes, outcome	of pregnancy	v									
The law requires that the death certificate has been signed by the attending ogge 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 \sum Yes 2 \sum No	1□Live birth 4□Pregnant a	2 Fetal de	ath 3 🗆	Ectopic preg				23	d. Date of delined Month	Day Year		
t the c by the achec	hysi	9 Unknown	9□ Unknown											
ss tha gned be det	by P	Part II. Dther significant conditions co	ntributing to death I	but not resultin	ng in the un	derlying cau	ise given i	n Part I.	23e. Did to	bacco use	contribute to	the cause of death?		
equire sen si									1 🗆 Y	'es 2 🗆	No 3 ☐ Pro	bably 4 Nunknown		
law I	ompleted								24a. Was autop	sy	prior to c	opsy findings available ompletion of cause of		
	O								1 Yes	med? 2X No	death? 1 ☐ Yes	2 □ No		
siciar certif recto	Be	25. Was case referred to medical examiner?	lospital: 🚜			-7.00	Othor	6. Place of Deati			701 1011			
Physer this eral di	n; To	27. Manner of Death	28a. Date of Inj	ury 28	VOutpatient 3b. Time of		c. Injury at Work?	4 ☐ Nursing Ho	me 5 Hesic 28d. Describe h			ity)		
ath. r: Afte	atlo	1X Natural 5 ☐ Pending investigation	(Month, D	ay Year)	Injury	М		2 🗆 No						
r Atta	Certification;	3 Suicide 6 Could not be determined	28e. Place of In	ijury - At home	e, farm, stre	eet, factory,	office		28f. Location (S City or Tox		Number or Ru	ral Route Number,		
oital ours af urs af arat D	Cel													
Hosp 24 ho Fune Hely f		29a. Certifier 1 XCertifying Phy (Check only 2 Medical Exam	iner: On the basis and manner s	of examination	edge, death n and/or inv	occurred at restigation, in	the time, n my opini	date and place, ion, death occurr	and due to the ored at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)		
	dica	one)					License ni	umber		29d. Date signed (Month, Day, Year)				
To the within To the	Medical	29b. Signature and title of certifier	K			29C.	LICETISE III	411101	'	Lou. Date	signed (Month	, Day, Year)		
To the Hospital or Attanding Physician: within 24 hours after death. To tha Funeral Director: After this certified completely filled in by the funeral director.	Medica		1											
To the within To the comple	Medica		ompleted cause of	death (Item 23	3a) (Type, I	D5	52739				ARY 7,	. Day, Year) 2006		
171	Medica	29b. Signature and title of certifier	M.D., VA		AND H	D5 Print) EALTH	52739			JANU	ARY 7,			

DHMH 17 Rev 1/2001

			For State Registrer		State o	f Maryla		artment rtificate			and M	ental Hyg	iene () ()6	003	19
	D1		1. Decedent's Name (F	First, Middle, L	ast)							Date of Deat Month	h Day	Year	3. Time of	Death
	Physici /Medio		Ralph Ph	nilip R	izza								200		1902	М
	Examin	er	4a. Facility Name (If no							Location of	of Death		4c. County			
			Greater Ba					If Under	OWSO!		24 Hra	0.5	Balt	imor		
	Funeral		5. Social Security Number 165-34-706		Sex 1□xM 2□F	7. Age (In y	rs. last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day, Feb. 22	Year)	9. Birth	place <i>(State</i> o Intry) Sylvani	r Foreign
	Director		Usual Residence of De		21							Feb. 22	, 19441	enns	sylvani	<u>а</u>
	/land			0b. County		10c.	City, Town or Lo	ocation							10d. Inside Ci	ty Limits
	Man Han	to	Md.	Harfor	:d			Bel.	Air						1 🗆 Yes	2 ™ No
	r 28g	lrec	10e. Street and Number	ər				10f. Zip	Code			10	ng. Citizen of	What Cou	intry?	
	death with the Maryland ms 23e or 28a-f ahow	Funeral Director	902 Hammon	nd Cour	:t				2101	4			U.S.	Α.		
	dea	ner	11. Marital Status		12. Was Dece Armed Fo			Was Deced	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		ce - Ameri	ican Indian,	
98	or it	y Fu	1 Never Married		1 □ Yes If Yes, Gir	2 □ {No ⁄e		1 ☐ Yes 2	•			,,	Specif	1.	nite	
21215-0036	72 hours after natural', or ite sical Examina	d by	3 ☐ Widowed 4 ☐		Year or D	ates:	T 40: 0					1				
15	n 72 "nat	lete	(Specify		rade completed)		(Give	dent's Usua kind of wor DO NOT us	k done a	lurina mosi	t of worki	na	16b. Kind of B Raltim		county	911
12	within ene.	Completed	Elementary/Seconda	ary (0-12)	College (I-4or 5+)		atche		,			Dartim	J16 6	Journey	711
9	be filed within 72 hours after death with the Marylar ital Hygiene. Ind other than "natural", or Items 23e or 28a-1 ahow or other than "natural", or Items 23e or 28a-1 ahow event, the Medical Examinat must be nutilised at		17. Father's Name (Fire		•		_ d13p	accirc	<u>-</u> _			(First, Middle, N	faiden Sumar	ne)		
lan	id be lental ked c	To Be	Ralph P.	Rizza,	Sr.					Emma	a DeI	Luca				
Maryland	s 1 and 2 should be filed within." I Health and Mental Hygiene. Item 27 Ia marked other than "I other traumatic event, If a Mass	-	19a. Informant's Name	e/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	nd Numbe	r or Rura	I Route Number,	City or Town	, State, Zi,	p Code)	
	alth a 27 ls		Catherine	Rizza	/wife		902	Hammo	nd C	ourt,	, Bel	L Air, M	d. 210	14		
Baltimore,	as 1 and 2 of Health I Item 27 I		20a. Method of Disposi				o. Place of Dispo	sition (Nam	ne of ther place	9)		ate	20c. Location	- City or T	own, State	
Ë	Page nent ant: If ury o		`4 □Donation 5				el Air M	lem. G	dns.		1/09/	/2006	Bel Ai	r, Ma	1.	
alt	permit. Pages 'Department of P Important: If Ite eny Injury or of		21. Signature of Funer	ral Service Lic	ensee	_	2:	2. Name and	d Addres	s of Facilit	y cal F	Home of	Bel Ai	r. Ir	1C.	
<u>m</u>	897		16	11								ad, Bel				
	Physician /Medical		23a. Part1. Enter the c shock, or heart fe Immediate Cause (Fin disease or condition resulting in death)	ailure. List on	a. Parion	eatic						respiratory arre			Approximate Interval Betwoen Conset and Cons	ween
	Examiner	ler	Sequentially list condit if any, leading to imme	tions, ediate	b. Due to	(or as a cons	sequence of):									
8760, ₹	icate be executed physician and s the burial-transit	dical Examiner	if any, leading to imme cause. Enter Underlying Cause (Disease or inju- that initiated events resulting in death) Las		c. Due to	(or as a cons	sequence of):									
P.O. Box 6	law requires that the death certificate as been signed by the attending phys. 2 should be detached for use as the	by Physician/Me	IF FEMALE: 23b. Was decedent pr in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	onths?		ointh 2 ☐ F nant at time o	etal death 3[⊒Ectopic pre ☐ Other (spe						ate of delivonth	-	/ear
	res that igned b	y P	Part II. Other significa	ent conditions	contributing to d	eath but not	resulting in the u	nderlying ca	ause give	in in Part I.		23e. Did tob	acco use con	tribute to t	the cause of d	eath?
Records,	w require been sig should b	ed b	Gastrointe	estinal	bleedi	ng						1 🗀 Ye	s 2 No	3 🖺 Pro	bably 4 □U	Jnknown
S	aw re	Completed	Resolving	acute	renal fa	ailure)					24a. Was as		Were auto	opsy findings a	available
R	0 = 0	E	Diabetes									autops perform TYYes 2	red?	death?		1056 01
Vital		Be C	25. Was case referred	I to medical						26. Place	of Death	(Check only on		761		
-	dis di	To E	examiner? 1 ☐ Yes 2 ➡ No		Hospital: 1 ₩	Inpatient 2	ER/Outpatie	nt 3 🗆 DO	A Othe	or: 4 🗀 Nu	rsing Ho	ne 5 🗀 Reside	nce 6 🗀 Oth	ıer (Speci	fy)	
n of	ng Ph fter th neral		27. Manner of Death	5 Pending	28a. Date (Mon	of Injury th, Day Year	28b. Time o	f 2	8c. Injury Work	at ?		28d. Describe ho	w injury occur	red		
Sio	endii eath. or: Ai	catle	2 🗖 Accident	investigat	1			М		res 2□	No					
Division	or Att after de Diract	Certification;	3 Suicide 4 Homicide	6 Could not determine	200. Place	of Injury - A ing, etc. (Sp	t home, farm, st ecify)	reet, factory	, office		1	28f. Location (Sti City or Town		er or Rur	al Route Num	ber,
	To the Hospital or Attending Prwithin 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edical C			Physician: To the aminer: On the band man)
	To the within 2 To the Complet	Me	29b. Signature and title	e of certifier	C 1			29c	. License	number		29	d. Date signe	d (Month,	Day, Year)	
) Was	Janel L	hegel	MD		D	2888	5			01/05/	/2006		
	11		30. Name and address	s of person wh	o completed caus	se of death (Item 23a) (Type,						,,			
	10		Howard L.	_Sieae	L, M.D.	6701 N	. Charl	es St	., B	altim	ore,	MD_2120	04			
	Sta	ite	31. Date filed (Month,	Day Year)		gistrar's Si		Constitution of the								

				State of Ma					-	•	ie.	00220			
		•	1 - State Registrar		•		tificate of L			leg. No.	0	00320			
	Dhysisis		1. Decedent's Name (First, Middle, Las						2. Date of Dea Month		Year	3. Time of Death			
	Physicia /Medic		Linda MAy I						Jan 8	3 2006		C. ZopM			
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, or Essex	Location of Death			4c. County of Death				
		362 Stillwater Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)						If Under 24 Hrs.	8. Date of Birth	Balti		ace (State or Foreign			
	Funeral Director			□M 2□F		Yrs.	Months Days	Hours Min.	Dec. 3	1939 WestVirgini					
	P .		Usual Residence of Decedent												
	anylar show	_	Md Baltimo	ore	10c. City, Town or Location Essex					10	0d. Inside City Limits 1 ☐ Yes 2 🛣 No				
	15 M	ecto	10e. Street and Number				10f. Zip Code	10f. Zip Code 10g. Citizen of What C							
	be filed within 72 hours after death with the Maryland Hygiene Hygiene 4 Hygiene do ther then "naturel", or teme 23s or 28s-f show do ther then "naturel", or temper must be ricitified at event, I'm Medical Examinar must be ricitified at	Funeral Director	362 Stillwate	er Road			2122	1	USA		,.				
	me 2;	nera	11. Marital Status	12. Was Decedent B				spanic Origin? (Sp n, Mexican, Puerk	pecify Yes or No-						
٥	or Ite	/Fui	1 Never Married 2 Married	1 ☐ Yes 2 ☑ N	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes 25 No	Specify:	o moan, etc.)	Specify:	, White, e				
2	hours ure!',	d by	3 Widowed 4 Divorced	Year or Dates:							WILLE				
γ	n 72 "nat	Completed	15. Decedent's Ed (Specify only highest gra		(Give	lent's Usual Occupa kind of work done of OO NOT use retired	lu <i>rina</i> most of wor	king		. Kind of Business/Industry					
717	filed within 72 Hygiene. Other then "nai ent, it a Medic	ошь		Elementary/Secondary (0-12) College (1-4or 5+) Clerk						Beth 8	Beth Steel				
פַ	should be filed word Mental Hygier marked other the imatic event, in	Bec	11th 17. Father's Name (First, Middle, Last)	st)				18. Mother's Nam	ne (First, Middle,	Maiden Sumame	n Sumame)				
<u>Ja</u>		70 E	Roy Ferguson					unkno	own						
Maryland 21215-0036	S Pe a		19a. Informant's Name/Relationship (-	y or Town, State, Zip Code)				
	1 and 2 Health tem 27 other tr		Thomas Ross / h	nusband			Stillwat sition (Name of	ter Roa	d Baltı Date	more MI 20c. Location - C		wn State			
وّ	Pages nent of h int: If ite		1 ⊠ Burial 2 ☐ Cremation 3 ☐		cemei	tery, cren	natory or other place.		12/06		-				
Baltimore,	permit. Pages 1 a Department of Hes Important: If Item eny injury or othe		4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer		0 0	. Name and Addres									
ä	permit. Departm Importa eny inju		RTIANN	(Vis			e Ave.							
-	Elsi		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused	the death. D	o not ent	er the mode of dyin	g, such as cardiac	or respiratory an	rest,	212	Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	MI	tasta	tie	Pana	100110	Canco	74./		Onset and Death			
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Mutcustatic Panciealic Cancer Due to (or as a consequence of):												
4	Examiner	L	Sequentially list conditions, b.								\perp				
	ed isit	Jine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
	xecut and	xan													
09/	te be executed ysicien and se burial-transit	calE		d											
89	w requires that the death certificate been signed by the attending phys should be detached for use as the														
Box	th cer lendin r use	an/N	IF FEMALE: 23b. Was decedent pregnant				23d. Date of delivery								
Э.	e dea	sici	sici	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	4 □ Pregnant at time of death 5 □ Other (specify)					Mont	Month Day Year			
P.O.	hat th	by Physician/Medi	Part II. Other significant conditions of	ontributing to death b	ut not resulting	n in the u	nderlying cause give	en in Part I	23e. Did to	tobacco use contribute to the cause of death?					
ds,	signe d be c									•					
Ö	v requ been shoul	Completed									24b. Were autopsy findings available				
Re	he lav e has	mb					med? pr	prior to completion of cause of death?							
ta	en: T tificat tor, pë	0	25. Was case referred to medical	25. Was case referred to medical 26. Plac							1 Yes 2 No 1 Yes 2 No				
\bar{2}	ysici is cer direct	To B	examiner? 1 Tes 250No	Hospital: 1 Inpatie	utal: Other				lome 5 Resid	r (Specify	<i>'</i>)				
Division of Vital Records,	Attending Physicien: The law requires that the death certificat rideath. ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the funeral director, page 2.		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Inju (Month, Da							28d. Describe how injury occurred				
	tendi leath. tor: A the fu	cati	2 Accident investigatio 3 Suicide 6 Could not b		М			Yes 2□No	004 1						
Σ	or At after d Direct in by	Certification:	4 Homicide determined	eet, factory, office		Street and Number m, State)	r or Hura	i Houte Number.							
_	Hospital or 24 hours afte Funeral Dir itely filled in		29a. Certifier 1 Certifying PI	nysician: To the best	of my knowled	dge, deatl	occurred at the tin	ne, date and place	and due to the	cause(s) and man	ner as st	ated.			
		edicai	(Check only 2 Medical Example)	miner: On the basis o and manner st	f examination	and/or in	vestigation, in my o	pinion, death occu	irred at the time, o	date and place, ar	nd due to	the cause(s)			
	To the To the comple	ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, 1									Day, Year)			
	. <		> Shelden Miliu, MD 018598 1/9/06								16				
1	2		30. Name and address of person who	G.	01.	a) (Type,	Print) belphi	. D	2.	- lax					
4	V	,te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature		Delphi	AKOA	> (AL	10. MD					
	Sta	ne	10N 1 0	2000		8 1	TORAL !								

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James I 06-207 AKG	E. Robe	ert	Please Unpend item#23a,PII, 1- For Registrar	Type or Pring 27, 28a f. per State of Ma	it in E ME C8 arylan					III Copies Mental Hy	Are	Legible.	00322	
AKG	Physici		1. Decedent's Name (First, Middle, Las JAMES ELLE		rs	Cei	tificate (ot D	eatn	2. Date of De Month	Da	sy Year	3. Time of Death 11:30 A ^M	
0 8/8	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give 2 Lochmoor Court 5. Social Security Number 227-62-8942 X		4b. City, Town, or Location of Lutherville ge (In yrs. last birthday) If Under 1 Year If Under 2			11e If Under 24 Hrs.	Death 4c. County of D					
) brewardand	or 28a-f show	Direc	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor 10e. Street and Number 2 Lochmoor Court	e	Lutherville 10c. City, Town or Location						10g. C	10d. Inside City Limits 1 □ Yes XX No. 10g. Citizen of What Country? USA		
1215-0036 within 72 hours after death with the Maryland	s 1 and 2 should be filed within /2 hours after death with the Maryla if Health and Mental Hygiane. If the marked other than "natural", or iteme 23a or 28a-f sho other traumatic event, the Medical Examinar must be notified at	ed by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes Arm If Yes, Give Year or Dates:	1 L Yes X2 k No Specifi				panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh	Race - American Indian, Black, White, etc. ecify: White	
Baltimore, Maryland 21215-0036	should be filed wiftin 72 nd Mental Hygiane, i marked other than "na umatic event, the Medici	Be Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	de completed) College (1-4or 5	+)	(Give kind of work done during most of working life. DO NOT use retired) EXECUTIVE Producer 18. Mother's Name (First, Middle, Mai								
re, Maryla	permit. Pages 1 and 2 should be lied writin Department of Heatth and Mental Hygiane. Important: If tem 27 is marked other than any injury or other traumatic event, Ita Ma pages.	ပ္	Hubert James Roberts 19a. Informant's Name/Relationship (Type, Print) Louise Hill Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 20c. Method of Disposition 20b. Place of Disposition (Name of completely, crematory or other place) 20c. Location - City or Town, State, 2 20c. Location - City or Completely, crematory or other place)								093			
Baltimo	permit. Page Department of Important: If any Injury or once.		Dulaney Valley Mem Gardens 1/11/06 Luthervill 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6500 York Road Baltimore, Mitchell-Wiedefeld Funeral											
	hysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Acute Alcohol Intoxication Due to (or as a consequence of):											
8760,	o	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.		1212								
Division of Vital Records, P.O. Box 68760,	that the death certificate is death of the attending physic detached for use as the b	Physician/Medical	in the past 12 months? 1								23d. Date of de Month	livery Day Year		
cords, F	w requires that been signed is should be det	Completed by P	0-1:1							Yes 2	pacco use contribute to the cause of death? as 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available			
/ital Re	icien: The tar certificate has rector, page 2	Be Comp	autopsy prior of arth? 25. Was case referred to medical symmetric and the symmetri									completion of cause of		
sion of \	Ing Phys After this uneral di	Certification: To	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence Manner of Death 28a. Date of Injury FNd 28b. Time of Injury FNd 28c. Injury at Work? 1 Yes 28d. Describe how injury occurred University Universit								ink			
Divi	늘 얼 등 등		3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found at residence 28f. Location (Street and Number of R City or Town, State) 2 Lutherville, MD 28g. Certifier 29g. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner a							noor Court				
` 4	To the Hospital within 24 hours a To the Funerel I completely filled	Medical	(Check only one) CMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and durand manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mor											
			30. Name and address of person who	MID		111	•			imore,				
į,	Sta Regist		31. Date filed (Month, Day, Year) JAN 1 0	32. Reo tr	ar's Signa	ture	frest)	,						

		State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 0 0 6 0 0 3 2									23					
			Decedent's Name (First, Middle, Last								2. Date of Death 3. Time of Death					
	Physicia		Julia	G.	Ric	hards	on				Month Janua:	rv 6.	Year 2006	8.5	30P M	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number			4b. City, To	wn, or L	ocation of	f Death			County of De		201	
	LAGITITI	·	Heritage Center				Dur	ida1k	;			Balt	imore			
	Funeral		Social Security Number 6. Security Number		ge (In yrs. las	t birthday)	If Under 1	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt	h v. Year)	0.00	rthplace (State	or Foreign	
	Director			N 2∏F	87	Yrs.	IN ONLING	Juju			Month, Da March	7,19	18	aryland		
	pu 🛊	-	Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation					-		10d. Inside C	ity Limits	
	faryle sho	ō	MD Baltimo	re	,		dalk								2 (X No	
	28a-1	ect	10e. Street and Number			10f. Zip Code						10a. Citiz	en of What C	Country?		
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show dical Executed out the notified at	Funeral Director	7546 Ives Lane				21222					-	U.S.A.	,		
	heath	era	11. Marital Status	12. Was Deceden	t Ever in U.S.	13.	Vas Decede	nt of Hisp	panic Orig	jin? (Spe	cify Yes or No Rican, etc.)	- 1		encan Indian,		
(0	or Itar	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces	.? 1 No			V .		, Puerto F	Rican, etc.)	- 1	Black, Wh			
8	ral', o	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates	:		1□Yes 2[_] NO	Specify:				Specify: W	hite		
5-0	72 hc	Completed	15. Decedent's Ed (Specify only highest grad			16a. Decedent's Usual Occupation (Give kind of work done during most					most of working			Kind of Business/Industry		
2	within lene. than "I	du	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Retail			d) 18. Mother's Name (First, Middle, Ma			Г	lonartn	ent Sto	ro	
2	filed w Hygie othar t		10 17. Father's Name (First, Middle, Last)											lent ott	71 C	
anc	ntal Find	Be	Martin Joseph Mu					11			Sophia Snyder					
Ë	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene. Int: If itam 27 is marked other than "natural", or itams 23a or 28a-1 show int: If itam 27 is marked other than "natural", or itams Exercities is a conflict at your other traumatic event, the Madical Exercities is the notified at	2	19a. Informant's Name/Relationship (7	vae. Print)		19b. Mailir	na Address (Street an	d Numbe	r or Rura	Route Numbe	er. City or	ty or Town, State, Zip Code)			
Maryland 21215-0036			Richard Richardso				Park				cimore,					
ē,			20a. Method of Disposition		cen	ce of Dispo	sition (Name	of er place)	1		ate	20c. Lo	cation - City o	r Town, State		
Ē			1 ☐ Burial 2 🏋 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from Stat)	A I	-	ematro			1/9/	/06	Bal	timore	, Maryla	and	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signeture of Funeral Service Licen	S88	,	22	Name and harles	Address S.	of Facility Zeil	ler &	Son,	Inc.				
	<u></u> <u> </u>		23a. Part1. Enter the disease, or comp	evan	ad the death		1224 E	iste	III AV	enue	e Ball	tmore	e, Mar	yland 2		
			shock, of heart failure. List only	one cause on each	line.	DO 1101 9111	er the mode	or dynnig,	Sucii as	cardiac oi	i respiratory a	ilost,		Interval Be Onset and	tween	
	Physician /Medical Examiner parisis and parisis transit parisis and parisis transit parisis and parisi		Immediate Cause (Final disease or condition resulting in death)	a. MAL	N107	TRI	110	1/_								
				Due to (or a	s a conseque	UER	5 1) I	ME	N.	511					
		er	Sequentially list conditions, if any, leading to immediate b. DLZHEMERS DEMEN FIA Due to (or as a consequence of):													
V		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events that initiated events													
ó	an an irial-tr															
8760,	ate be physici the bu	Ilcal														
9	e as 1	Mec	IF FEMALE:	00. 11												
Вох	eath certific attending p for use as	lan/	23b. Was decedent pregnant in the past 12 morths?							2	3d. Date of d: Month		Year			
0	that the de ned by the a detached i	Physician/Medical	1													
Δ.	res that t igned by be detar		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac								obacco u	co use contribute to the cause of death?				
ds	puires n sign	d by									1 Yes 2 No 3 Probably 4 of					
performed?/ der									24a. Was	an 24b. Were autopsy findings ava			available			
									death?	th?						
ta	(0	Be C	25. Was case referred to medical						26. Place	of Death	(Check only o			24110		
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpa	tient 2 🗆 E	R/Outpatier	nt 3 DOA	Other	4 2 Nu	rsing Hon	ne 5□Resi	Residence 6 Other (Specify)				
			27. Manner of Death 1	28a. Date of Ir (Month, L	jury 2 Day Year) 2	28b. Time o										
0	ttandin death. ctor: Af / the fu	atlo	2 Accident investigation	1			М		es 2 🗆 l	No						
Division	for Att after de Diracte in by t	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locati City of							28f. Location (. City or To	on (Street and Number or Rural Route Number, r Town, State)					
Ω	pital o		29a. Certifier 1 Certifying Ph	ysician: To the be	et of my knowl	ledne deat	h occurred a	t the time	date an	d place a	and due to the	cause(s)	and manner	as stated		
	To tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	edical	(Check only 2 Medicel Exam		of examination										s)	
	To th within To th compl	Me	29b. Signature and title of certifier				29c.	License	number	-		29d. Date	a signed (Mo	nth, Day, Year)		
			Sainve	Ce Ti	alka	MI) /	2	71	88		11	7/06	2		
	3		30. Name and address of person who	completed cause o	f death (Item 2	23а) (Туре,	Print)		0	- /	7-21.	Λ.	217	7/10	>	
			31. Date filed (Month, Day, Year)	UNIC L.	strar's Signatu	Ire .	riace) (e	010	CULIC		()	4122	6	
	Sta Regist		10014	2006	a	8 0	make s									
DI	MH 17 Rev 1/2	¥ .	UNIX U Z	UUU I	100000		Por Paris									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#20c, perFH (4851,1/10/06 TT State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year STURGIS JAN 6cm 06 3:15PM BESSIE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) HOWARD LORIEN DURSING COLLMBIA HOME If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🗷 F Yrs PIR. 54. 6275 MD 01-06-1947 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No COLUMBIA MD HOWARD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #3 9655 BASKET RING ROAD 21045 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritaf Status 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 DDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Colfege (1-4or 5+) N A Elementary/Secondary (0-12) DAY CARE PROVIDER SELF EMPLOYED 11TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM JONES LILLIAN NICKENS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5815 STEVENS FOREST RD. Sturgis (DAUGHTER) SHAWNTIL COLUMBIA 21045 MO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MEADOW RIDGE 01-11-2006 4 ☐ Donation 5 ☐ Other (Specify) ELKRIDGE ROAD 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Sign ture of Funeral Service Licensee Laugh 5151 BALTO. NATT PIKE, BALTO. MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final Docare Sra monun Due to (or as a consequence of) disease or condition resulting in death) Sep S 1 S Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Monet CREATIC TUMOR that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of defivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 44 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2. No 26. Place of Death Check only one 25. Was case referred to medical 1 Yes 2 No

Physician /Medical Examiner The law requires that the death certificate be executed

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permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

Funeral

Director

in than "natural", or itema 23a or 28a-f ahow the Modical Examinatinasi be notified at

Directo

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with the Maryland

death v

hours after

iges 1 and 2 should be filed within it of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examine physicien and s the burial-transit Physician/Medical attending pl been signed by the should be detached Ď Completed page 2 s certificate After this certification funeral director, a Be Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Division of Vital Records, P.O. Box 68760.

Attending Physician:

Hospital or

the

death.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Ø No 9 Unknown

27. Manner of Death

1 Matural

2 Accident 3 Suicide

4 Homicide

29a. Certifier

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Destifying Physician: To the best of my knowledge ideath occurred at the time, date and place and dual to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

MD ed ge

DOOS 3150

JAN 790 2006

30. Name and address of poon who completed cause of death (ftem 23a) (Type, Print) GUPTA

JAN 1 0 2006

SNAWWNYA 31. Date filed (Month, Day, Year)

5 ☐ Pending

investigation

6 Could not be determined

9650 32 Registrar's Signature South.

SULTELLO COLUNBIA 21045 SANTIAGO ROAD

State Registrar

3

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier [] [] 5 00325 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year DOROTHY B. SYKES 05. 3:00 PM 01. 2006 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death NA JOSEPH RITCHIE HOSPICE BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)

MD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Days Hours 1 □ M 287 F Yrs. 217.18.0664 12.16.192 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 □ No NA MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 420 N. CHAPELGATE LANE 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED CONSTRUCTION 12/11 GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EDWARD BURMAN MARY WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SLAUGHTER 2250 THIRD PLACE N.E. BERMINGHAM, AL SUNNETIA 35215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State 01-09-06 BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) GREENMOUNT 21. Signature of Funeral Service Licensee CREMATION SERVICES 2) augh 5151 BALTO. NATE PIRE BALTO. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THE LUNG WITH EXTENSIVE ONE MONTH Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Directo

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic event, the Madical Exeminal has been relified at once.

use as the burial-transit

Box 68760.

Division of Vital Records, P.O.

Examine

Physician/Medical

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Certification:

death. after death

23b. Was decedent pregnant in the past 12 months? 9 Unknown

25. Was case reterred to medical examiner?

29b. Signature and title of certifier

1 ☐ Yes 2 No

27 Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

24a. Was an performed 1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No N/A

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No М 28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 Pending

investigation

29c. License number D22488 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

220 TUNBRIDGE RUAD, BALTIMERE-, MD 212/2 M.D.

State Registrar



To the Hospital o within 24 hours aft To the Funaral Di

2 ER/Outpatient 3 DOA

Amend item#17,perfH,C31,1/10/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JÄNÜARY Da 08 2006 4:40A M **JAMES** Α. SCROGGINS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 11/18/1935 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthptace (State or Foreign Days Hours X M 2□F 216-30-8638 70 MARYLAND Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits MD HARFORD ABINGDON 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1103 CULLODEN COURT 21009 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: BLACK XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) U.S. POSTAL Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR 12TH SERVICE 3 YEARS 17. Father's Name (First, Middle, Last) Scroggins 18. Mother's Name (First, Middle, Maiden Surname) MOSSON SCRUCCINS HELEN CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN SCROGGINS 1103 CULLODEN COURT, ABINGDON, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State 01/13/06 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD Letter the disease, or complications that caused the death ck, or heart failure. List only one cause on each tine. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease of condition resulting in death) Onset and Death Due (or as a consequence (f) D. Sequentially list our differs, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Y*e*s 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

M 800436384 aragins, James hours after death

burial-transit the attending physicien use as the certificate the Hospitel or Attending Physician: After this filled in by

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Madical Examinar must be profiled at

importent: if item 27 is: eny injury or other treun once.

Physician /Medical

Examiner

d 2 should be filed within 7: ih and Mental Hygiene. 7 is marked other than "n.

within 24 hours after deat To the Funerel Director:

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and little of certified low

TCCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

01-08-2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wa 31. Date filed (Month, Day, Year)

0 2006



				artment of Health and Menintificate of Death		ene 006	00327
			Decedent's Name (First, Middle, Last)		ate of Death		3. Time of Death
	Physici /Medic		Raymond Scalise		nuary	5, 2006	10:30 P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deatl	n .
Ι			7502 Cypress Avenue	Dunda1k		Baltin	
r	Funeral Director		5. Social Security Number 6. Sex 1 2 1 2 1 2 1 2 1 5 1 1 2 1 1 2 1 1 2 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1	Months Days Hours Min. (A	ate of Birth Wonth, Day, Y	(ear) 9. Birth	nplace (State or Foreign untry)
			184-20-8715 78 Yrs. Usual Residence of Decedent	J.	AN 13,	1927 Penr	nsylvania
	yland		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	e-fs	Director	Maryland Baltimore	Dundalk			1 ☐ Yes 2 X No
	라 타 or 28	Oire	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	untry?
	ath w	ral	7502 Cypress Avenue	21224		USA	
	er de Itams	nne	Armed Forces?	Was Decedent of Hispanic Origin? (Specify \ If Yes, specify Cuban, Mexican, Puerto Ricar	Yes or No- n, etc.)	14. Race - Amer Black, White	
36	within 72 hours after death with the Maryiand ene. then "naturel", or Itams 23a or 28e-f show the Madical Examiner must be notified at	by Funeral	1 □ Never Married 2 □ Married 1 □ MYes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 📉 No Specify:		Specify:	White
9	thou ature	ed		dent's Usual Occupation	16	b. Kind of Business/I	
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2	d wit giene er the	Completed	12 Machin	ne Shop Supervisor		ept. of Sa	7
<u> </u>	should be filed within 72 hours after death with the Marylan of Mental Hygjene. markad other then "naturel", or Itams 23a or 28e-f show imatic event, the Mcdical Examiner must be multified at	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs	st, Middle, Ma.	iden Sumame)	
<u>X</u>	should to the Ment marked umatic of	٥	Anthony Scalise	UNK.			
Maryland 21215-0036	2 a a		No. of the contract of the con	ng Address (Street and Number or Rural Rou	ite Number, C	City or Town, State, Z.	ip Code)
	ges 1 and t of Health If item 27 or other tr		Elizabeth Scalise/Wife 7502 20a. Method of Disposition 20b. Place of Dispo	Cycress Avenue Line		ND 21224	
و			T Durial 2 Cramation 3 Hamovat nom state	matory or other place)		c. Location - City or T	
altimore,	it. Partmer			ematory, Inc. 1/6/06 2. Name and Address of Facility Consequence		Baltimore,	
Ba	permit. Page Department of Important: If any injury or once.		Tolund to (New relie	Crema	ation S	Society of	MD, Inc.
	51		23a. Part1. Enter the disease, or complications that caused the death. Do not enter	99 Frederick Road Baller the mode of dying, such as cardiac or resp	Ltimore piratory arrest	, MD 2122	8 Approximate
	Pnysician		shock, or heart failure. List only one cause on each line.		,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a	METIVE PULMONARY	D125	FASE	10 YEARS
	Examiner		Sequentially list conditions b.				
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
X	and and trans	Examiner	that initiated events c.				
8760,	death certificate be executed e attending physician and id for use as the burial-transit	alE	Due to (or as a consequence of):				
587	ficate phys s the	edlcal	d				
Rox	eath certific attending p for use as	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	renv
	death e atte id for	Physiclan/M	in the past 12 months? 1 Yes 2 No. 1 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
ت ت	by the a	hys	9 Unknown				
	law requires that the as been signad by th 2 should be detache	by F	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 2	23e. Did tobac	co use contribute to	the cause of death?
ord	w require been sig should b	ted		-	1 Yes	2 No 3 Pro	bably 4 Unknown
Records,	e 2 sl	Completed		2	4a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
	: The law icate has			1	performed ☐ Yes 2 🖼		2 🗆 No
VItal	Physicien: The this certificate ral diractor, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 Tho Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Che			
0	Phys or this oral di	Η.,	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 28d. D		e 6 ⊡Other (<i>Speci</i> injury occurr <i>e</i> d	fy)
0	nding th. :: Afte	ation	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,	
DIVISION OF	Atter	ific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)			t and Number or Run	al Route Number,
5	tel or rs afte el Dir ed in	Certification:	building, etc. (Specify)		ity or Town, S	state)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only (Ch	occurred at the time, date and place, and duvestigation, in my opinion, death occurred at	ue to the caus	e(s) and manner as s	stated.
	thin 2 thin 2 the I	Med	and manner stated.				
	Twi G O	-	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
	J.		30. Name and address of person two completed cause of death (Item 23a) (Type, F	D0051021	Ja	inuary 6,	2006
	1.		4 4 4 4 4 4 4	UL PLACE, SUITE 715	RA.	TIMOCE and	2x14ND 21202
	Sta	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	-creme June 115	VAL	The same	7 67770 01602
	Registr		JAN 1 0 2006				

		1 - State of Maryla State of Maryla		artment of Health a rtificate of Death	nd Mental Hygie	7000 00370
	2	Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year 3. Time of Death
Physic /Medi		Frances Virginia	Schia	ffino	January	7 2006 2101 M
Examir		4a. Facility Name (If not institution, give street and number) 5.+. Agnes Healthcare		4b. City, Town, or Location of Baltimore		4c. County of Death N/A
Funeral Director		212-09-9889 ¹□м 2XF	yrs. last birthday, 91 Yrs.	If Under 1 Year If Under 2 Months Days Hours	Min. 8. Date of Birth (Month, Day, Ye MAR 30,	9. Birthplace (State or Foreign Country) Maryland
land ow		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or L	ocation		10d. Inside City Limits
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or items 23e or 28a-1 show sumatic event, the Medical Examinat must be notified at	ctor	Maryland Baltimore		Catonsv	ille	1 ☐ Yes 2 No
with th	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
eath v	era	46 Melvin Avenue 11. Marital Status 12. Was Decedent Ever in	n IIS 13	21228 Was Decedent of Hispanic Orig	in? (Specify Ves or No-	USA 14. Race - American Indian,
fier d	Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	10.5.	If Yes, specify Cuban, Mexican,	Puerto Rican, etc.)	Black, White, etc.
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filled within 72 hours all Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or myoritant: if item 27 is marked other then "naturel", or myoritant: or the fraction of the fractions.	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No Specify:		Specify: White
15-(Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most DO NOT use refired)	of working	b. Kind of Business/Industry
within	dwo	Elementary/Secondary (0-12) College (1-4or 5+)		ashier	10	Banking
filed Hygied other	BeC	17. Father's Name (First, Middle, Last)			's Name (First, Middle, Mai	
/lar	To B	James Hector Schiaffing)	P	Mary Susan	Hawkins
fary 2 sho and is mu		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number		
ore, Maryla ss 1 and 2 should of Health and Mer litem 27 is marks		Mary P. Schiaffino/Sister		Melvin Avenue		le MD 21228 c. Location - City or Town, State
Pages Pages Then toff the control of		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cre	matory or other place)	CONTROL CONTROL	MANUAL CONTRACTOR CONTRACTOR
Baltimore permit Pages 1 Department of E Important: If the any injury or of		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Lawred A. Gregor Club		ne Park 2. Name and Address of Facility		Woodlawn, MD
Balt permit Depart Import any inj		Edward A. Gregorchik			machabb ru	neral Home, P.A. nsville, MD 2122
		23a. Part1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	leath. Do not en	ter the mode of dying, such as c	ardiac or respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	NYOCAR	DIAL INFADETI	(A N	Onset and Death
/Medical Examiner				DIAL INFARCTI		
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):	cardiovas ular	disease	15 years
ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
60, be executed ciden and burial-transit		resulting in death) Last Due to (or as a con-	sequence of):			
8760, cate be exphysicien the buria	dical	d				
OX 61 certific	/Mec	IF FEMALE:				
Bath Bor	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 University 12 months? 1 Yes 2 No 2 University 12 months?	etal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
P.O. that the de by the detached	ysi	1 □ Yes 2 No 9 □ Unknown				
ords, P.O	by P	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
んんじどく ecords, law requires these been signe	led !	dehydration acute renal failure			1 🗆 Yes	No 3 Probably 4 Unknown
A S P S P S P S P S P S P S P S P S P S	Completed	acute renal failure			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The : The		hypertension			performed 1 ☐ Yes 2 🔼	
of Vital F Physician: Th this certificate	Be	25. Was case referred to medical examiner? Hospitat:		Other	of Death (Check only one)	
ting Physical di	7: To	27. Manner of Death 28a. Date of Injury	ER/Outpatie	III 30 DOX 40 NBIS	sing Home 5 Residence 28d. Describe how i	
Vision Vision Attending r death. ector: After	atio	1 Natural 5 Pending (Month, Day Year 2 Accident investigation	r) Injury	Work? M 1 ☐ Yes 2 ☐ N	0	
Division or Attending effer death. Director: After in by the tune in by the tune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp.	At home, farm, st	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, itate)
Chikt Division spite or Attention ours effer deal						
Schiefino, Fino To the Hospital or Attending Physician: The Within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check orly one) Check orly one) Check orly one) Check orly one) Check orly one) Check orly orly one Check orly one Check orly orly orly orly orly orly orly orly	knowledge, dea: nnation and/or in	th occurred at the time, date and exestigation, in my opinion, death	place, and due to the caus occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within To the comp	Z	29b. Signature and title of certifier	391	29c. License number	29d.	Date signed (Month, Day, Year)
		30. Name address of person who completed use of death (Jerome J. Swyder m. D. 31. Date like (Month, Day, Year) 2005 32. Registrar's Si	D	D 2264F	Jos	mary 7, 2006
'n		30. Name of address of person who completed duse of death (Item 23a) (Type	Print)	D	
	ate	31. Date lies (Month, Day, Year) 32. Registrar's Si	yooSou ignature	TH CATON AVENU	e Daltimore	, Maryland 21229
Regist		JAN 1 0 2006 Jane &	frank.	P		

		4	For State	State of Man	•	artment of H	lealth and Me		21116	00329
	Physicia		1. Decedent's Name (First, Middle, L	ast)	MITH			Reg. I Date of Death Month	ay Year	3. Time of Death
	/Medic	al -	PAUL		ou i i i	,	David Parity		4c. County of Deat	
	Examin	er	4a. Facility Name (If not institution, g		to 1	Columb	Location of Death		•	n
	Funeral		Howard County G 5. Social Security Number 6.	Sex 7. Age (/	LAI In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. 8	Date of Birth	Howard 9. Birt	hplace (State or Foreign untry)
	Director		212-07-1329	1 X M 2□F	89 Yrs.	Months Days	Hours Min.	(Month, Day, Yes		Maryland
	and w	-	Usual Residence of Decedent 10a, State 10b, County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl	ğ	Maryland Howa	rd		p11.	icatt Cit-			1 ☐ Yes 21 No
	r 28e	Director	10e. Street and Number	Lu		10f. Zip Code	icott City	10g.	Citizen of What Co	untry?
	th wit		3342 Chatham Ro	oad, Apt. I		2	21043		USA	
	tems	Funerai	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Speci In, Mexican, Puerto Ri	y Yes or No- can, etc.)	14. Race - Ame Black, Whit	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give Year or Dates: 1 C	1/12_/15	1 ☐ Yes 2 🎇 No	Specify:		Specify:	White
21215-0036	d within 72 hours after death with the Maryland jene. r than "natural", or Items 23a or 28e-f ehow the Medical Examble frout be rollified at	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occup	ation	16b	. Kind of Business	
215	within 7 ene. than "n	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	•		Developm	ent /
21	illed with Hygiene. other than	Con		5+	Ge	neral Mar			Manageme	nt
Maryland	be d o d	Be	17. Father's Name (First, Middle, La				18. Mother's Name (•	
ΪŽ	ti D F F	٦	Walter Paul Sn 19a. Informant's Name/Relationship		19b. Maili	ng Address (Street	Agnes and Number or Rural I	Lee His	-	Zip Code)
	12 ha		Paul Smith/Son		421	Westside	Boulevard	Catonsy	ille Mo	21228
altimore,	ges 1 and of Healt if Item 2: or other t		20a. Method of Disposition 1 □ Burial 2 ဩCremation 3		20b. Place of Dispo	osition (Name of matory or other place	Dat	9 20c	Location - City or	Town, State
Ë	Pag nent ent: I		`4 ☐ Donation 5 ☐ Other (Spec	cify)	Metro Cre	matory,]	Inc. 1/9/06	5	Baltimor	e. MO
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lic	halo	2	2. Name and Addre	Crei	nation So	ociety of	MD, Inc.
m	ans a d		Edward A. Gro	gorchik	e death. Do not en		derick Road		nore, MD	21228 Approximate
ı			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each line.				oophatory arroot,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Due to (or as a c	consequence of):	COPD				years
	Examiner		Sequentially list conditions	b ation	al a	cord rrhy-fl	nuia			days
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of):	l				
	and and al-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as a c	consequence of):					
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	dical E		d						
9	tificate ng phys as the		In reliate							
Вох	death certifica attending ph d for use as th	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	□Ectopic pregnancy	,		23d. Date of de Month	ivery Day Year
0.	ne dea the al	Physician/Me	1 Yes 2 No	4□ Pregnant at tin 9□ Unknown	ne of death 5	Other (specify) _			World	Day
۵	res that the de signed by the a be detached t		Part II. Other significant conditions	s contributing to death but	not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
rds	quires n sign ald be	d by						1 🗌 Yes	2 □ No 3 □ P	robably 4 Dunknown
O C	aw requir s been si 2 should	piete						24a. Was an	24b. Were at	utopsy findings available
of Vital Records,	The lav	Completed				<u> </u>		autopsy performed 1 Yes 2	? death? No 1 ☐ Yes	completion of cause of
/ita	ysicien: Th	Be (25. Was case referred to medical examiner?	l Itanialia		0.1	26. Place of Death (Check anly one)		
of \	S S	. To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: Inpatient	2 ER/Outpatie		4 Nursing Home	5 Residence		cify)
	ding I	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	/ear) Injury	Wor		d. Describe flow i	njury occurred	
Division	i or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could no	t be 28e. Place of Injury	· At home, farm, st	reet, factory, office	28			ural Route Number,
Ö	tel or A	Cert	4 Homicide	building, etc.	(эрвспу)			City or Town, S	idle)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best of examiner: On the basis of examiner state	xamination and/or in	th occurred at the tir nvestigation, in my o	me, date and place, an opinion, death occurred	d due to the cause at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	a (con , MD		29c. Licens			Date signed (Moni	
)	d		Attruding 30. Name and address of perso, wi	d'pho	sicon	DO	062545		au 6,	2006
	12			a	th (Item 23a) (Type	Print)	Ca 102 C	eder in h	e ann	21044
	St	ato	31 Date filed (Month, Day, Year)	32. Registrar'		- C1 170- C	The , C	00000	, , , , , ,	-1084
11"	Regist		JAN 1 0 2006	Assessed A	fra. M.	A				

			1 - For State Registrar	State of Maryl		artment of H			ene g. No. 006	00330
	Physici	an	1. Decedent's Name (First, Middle, Las		-			2. Date of Death Month	Day Year	3. Time of Death
1	/Medic	al	James W. 4a. Facility Name (If not institution, give			4h Cih, Tourn or	Location of Dec	January	- ,	8:45 A M
	Examir	er	Fairfield Nursin			4b. City, Town, or Crowns		un	4c. County of Deat	Arundel
140%	Funeral	N.	5. Social Security Number 6. Se	x 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hr		9. Birt	hplace (State or Foreign
	Director		251-05-4924	X M 2□F	91 Yrs.	Months Days	Hours Mir	NOV 16,		th Carolina
Crack	and		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or L	ocation				10d. Inside City Limits
	Mary -1 sho	tor	Maryland Anne Ar	ındel		Sot	ern			1 ☐ Yes 2X No
	h the	irec	10e. Street and Number			10f. Zip Code	CIII	10	g. Citizen of What Co	untry?
	23a c	Funeral Director	8489 New Cut	Road			21144		USA	
	tems	nue	11. Marital Status	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No	in U.S. 13.	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White	
36	ir, or	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ∐ Yes 2 M No If Yes, Give Year or Dates:		1 □ Yes 2X No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show he Madical Examiner must be notified at	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of Business/	Industry
218	ithin 7	Completed	(Specify only highest grad	College (1-4or 5+)	life.	kind of work done of DO NOT use retired,)	orking		
121	e filed within al Hygiene. I other then "	Cor		UNK	N	lanufacti		- 15 - Adidda A	Glass M	
and	buld be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle, Last)	UINK			18. Mother's Na	ame (First, Middle, M	laiden Surname)	JNK
Maryland	2 should be and Menta is marked raumatic ev	ဥ	19a. Informant's Name/Relationship (7	уре, Print)	19b. Maili	ng Address (Street a	and Number or F	Rural Route Number,	City or Town, State, 2	Zip Code)
	1 end 2. Health a Iem 27 is		James L. Stack	/Grandson					11e, MD	estate of the second
altimore,	of He of He fiterr		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	20	b. Place of Disp	osition (Name of matory or other place			0c. Location - City or	
Ē	Pag Iment tant: i		4 ☐ Donation 5 ☐ Other (Specify) <u>N</u>	Metro Cr	ematory,]	Inc. 1/	9/06	Baltimore	e, MD
Ball	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ODE.		21. Signatury of Funeral Service Lionn	me de		2. Name and Addres		remation	Society of	MD, Inc.
	40240		Edward A. Gre 23a. Part1. Enter the disease, or comp	gorchik					ore, MD 21	228 Approximate
B	Dhysisian		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.		•	g, 00011 d3 0 u 1011	io or rospiratory arro	J.,	Interval Between Onset and Death
S.d.	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cor	rsequence of):	na	-			
1	Examiner		Sequentially list conditions	b						
	pe #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):					
	and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cor	sequence of):					
8760,	cate be executed obysician and the burial-transit	aiE		4						
9	certificate be executed nding physician and use as the burial-transit	Physician/Medicai		d.						
Вох	eath certific attending pl	an/M	230. Was decedent pregnant	23c. If yes, outcome of pro		□Ectopic pregnancy			23d. Date of del	ivery
	e death the atter ned for u	sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time 9☐ Unknown		Other (specify)			Month	Day Year
P.0	that the dened by the a		Part II. Other significant conditions co	ontributing to death but no	t resulting in the I	Inderhina cause ave	on in Part I	23e Did tob	acco use contribute to	the cause of death?
of Vital Records,	8 5 6	d by		and the death but no	t rosulting ar the t	andonying dadas give	on mi r care i.			obably 4 □Unknown
COL	> 11 0	iete						24a. Was ar	24b Were au	topsy findings available
Re	0 - 2	Completed						autopsy	prior to d	completion of cause of
ital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of De	1 Yes 2 eath Check only one		2 □ No
≥ <	Physician: this certific ral director,	ျ	1 ☐ Yes 2 1 No		2 ER/Outpatie		4 Winursing	Home 5 ☐ Resider	nce 6 □Other (Spec	cify)
		ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Tîme d Injury	Work		28d. Describe ho	w injury occurred	
Division	l or Attending after death, Director: After in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be		At home, farm, st		Yes 2 □No	28f. Location (Str	eet and Number or Ru	ural Route Number
Ω̈́	P f f e	Certification:	4 Homicide determined	building, etc. (S	oecify)	. oot, tubiory, omoo		City or Town	State)	rar riodio rambor,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 V Certifying Ph	ysician: To the best of my	knowledge, dea	th occurred at the tim	e, date and place	e, and due to the ca	use(s) and manner as	stated.
	the H hin 24 the F nplete	Med	0.76)	and manner stated.	mination and/or ii					
	To To	~	29b. Signature and title of certifier) [//-	4	29c. License			d. Date signed (Monti	
	1,		30. Name and address of person who	completed cause of death	(Itam 23a) /Tuna	Print)	37/48		January 9,	2006
	,		Richard	S. Rees.	MD.	1220	E Jon	on Kl.	January 9,	rd
*	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	,		-10-1	-	
	Regist	rar	4711 + U 2000	KINGHE J.S.	A STEPPEN STEP	y				

			Please	Type or Print i					•	•	le.	
			1 - For Stata Registrar	State of Mary			of Health <i>of Death</i>			iene () ()	6	00331
	Physici /Medic		1. Decedent's Name (First, Middle, La Daniel J. Sti	si) pek					2. Date of Deat Month January	Day	Year 06	3. Time of Death 11:00 A M
	Examin		4a. Facility Name (If not institution, given Stella Maris			Tim	wn, or Location 10 NLUM			4c. County o	f Death timo	re
98.7	Funeral Director		5. Social Security Number 213-30-3087 Usual Residence of Decedent	7. Age (In	yrs. last birthday) Yrs.	If Under 1 \ Months D	Days Hours	Min.	8. Date of Birth (Month, Day, Jan. 18	, 1933	Coun	ace (State or Foreign lry) YLand
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show mith injury or other traumatic event, it a Medical Examinating man its motified at ances.	tor	10a. State 10b. County Maryland Baltimo		c. City, Town or Lo		ingsvill	e ² e		-	10	0d. Inside City Limits 1 ☐ Yes 2 🌠 No
	or 28a	Director	10e. Street and Number			10f. Zip Co	ode		1	0g. Citizen of Wi	nat Coun	try?
	ath wi	rai	11210 Sandyvale				2108	7		u.s.	Α.	
	er des	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Deceden If Yes, specify	nt of Hispanic O Cuban, Mexica	rigin? (Spe ın, Puerto I	cify Yes or No- Rican, etc.)	14. Race Black	- America White, e	
036	ours aft	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 No If Yes, Give Year or Dates:		1 □ Yes 2 X	No Specify	<i>r</i> :		Specify:	Wh	ite
21215-0036	in 72 ho n "natur Nedicel	Completed	15. Decedent's E (Specify only highest gr.	ade completed)	16a. Dece (Give life.	dent's Usual C kind of work of DO NOT use i	Occupation done during mo retired)	st of workir	ng	16b. Kind of Bus	iness/Ind	ustry
212	giene.	mo.	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5+)			Supervis			Beth St	eel	
and	d be filed vintal Hygie ed other i	Be	17. Father's Name (First, Middle, Last James Stipek)				ner's Name Utoliv		Maiden Sumame Ymanski)	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, it e Mi	J.	19a. Informant's Name/Relationship (,, ,			Street and Numb	er or Rura	l Route Number	City or Town, S		
	and 2 Health Im 27 Her tra	1 8	Patricia A. Stip							le, MD		
more	Pages 1 ent of H nt: If Ite ry or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	ob. Place of Dispo cemetery, crei Parkwood	matory or othe	er place)			20c. Location - C Baltimon	,	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra ance.		21. Signature of Funeral Service Lice		2:	2. Name and A	Address of Facil	irschi	munek Fi	uneral H	lomes	
17			23a. Part 1. Enter the disease, or com	plications that caused the						, MD 21	236	Approximate
100	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. METASTATI Due to (or as a co		CANCER						Interval Between Onset and Death
٤	executed in and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a ro	neaquionea of):							
68760,	sath certificate be exec attending physician an for use as the burial-tr	_	resulting in death) Last	Due to (or as a co	nsequence of):							
O. Box	the de	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregi Other (speci				23d. Date Mont		ry Day Year
s, P	res that igned to be det	by	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying caus	se given in Part	I.				e cause of death?
Records,	v requir been si should I	eted									_	ably 4 X Unknown
Re	ding Phyeician: The lav h. After this certificate has funeral director, page 2	Completed							24a. Was a autops perform	y pri ned? de	ere autop or to con ath?] Yes	sy findings available apletion of cause of
Vital	Physician: this certificantal director, I	Be	25. Was case referred to medical examiner?					e of Death	Check only on			20110
of \	Physic this c	7°	1 ☐ Yes 2 X No 27. Manner of Death		2 ER/Outpatie							HOSPICE
ion	Attending r death. ector: After by the funer	ation	1 XNatural 5 Pending 2 Accident investigated	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o Injury	M 280.	. Injury at Work? 1 ☐ Yes 2 ☐	4	ea. Describe no	w injury occurre	a	
Division	in Dig	Certification:	3 Suicide 6 Could not be determined		At home, farm, st Specify)	reet, factory, o	office	2	28f. Location (St. City or Town	reet and Number , State)	or Rurai	Route Number,
	Hospital 24 hours a Funeral etely filled	Medical C	29a. Certifier (Check only one) 29a. Certifying Pi	nysician: To the best of m miner: On the basis of exa and manner stated.	amination and/or in	h occurred at I	the time, date a my opinion, de	nd place, a ath occurre	and due to the ca	iuse(s) and man ate and place, ar	ner as stand due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and mainter stated.		29c. L	icense number		2	9d. Date signed	(Month, L	Day, Year)
	1		/				437	25		1/91	106	
*	6		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)		<u> </u>		11 1		
	,	ato-	DR. TARIQ MAHMO 31. Date filed (Month, Day, Year)	OD 2300 DUL	ANEY VAL	LEY RD.	TIMON	NIUM,	MD 2109	3		
4"	Sta Registi			006 there	Signature	and I						

		riedse rj	Ctata of Man	dend / D	· IIIdelible	A LL	ciisare All	copies	Ale Leg	ible.	
		For State	State of Mary	land / D	epartment	OTH	eaith and M	ental Hy	giene	6	00332
		Registrar			Certificate	OT L	Jeath		Reg. No.		
Physicia	n	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	Year	3. Time of Death
/Medica	al -	FRANCIS	A LBER	T	2076	SEN	_	JAN	6 201	06	23=19 M
Examine	er	4a. Facility Name (If not institution, give str	reet and number)		,		Location of Death		4c. Count	y of Death	
	g. -	UPPER CHESAPEAKE	MEDICAL	CENTE			AL			2 PO	
Funeral		5. Social Security Number 6. Sex		yrs. last birt	Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th Year) 0, 1926	9. Birthr	place (State or Foreign ntry) ryland
Director			79		rs.			Nov. I	0, 1926	ма	ryland
and *		Usual Residence of Decedent 10a, State 10b, County	10	c. City, Town	or Location						10d. Inside City Limits
Aaryll •ho	jo	Md. Harford			Abingd	on					1 ☐ Yes 2 No
the N	ect	10e. Street and Number			10f. Zip	Codo			10g. Citizen of	14/h et Cour	-1-2
with o	ਨੋ		Court No	2 /		2100	۵			S.A.	ntry:
Seeth Seeth	era	3512 Thomas Pointe	2. Was Decedent Ever					offy Voe or No			can Indian,
O ler d	Ë	1 Never Married 2 Married	Armed Forces?	111 0.3.	If Yes, spec	ify Cubar	spanic Origin? (Spe n, Mexican, Puerto i	Rican, etc.)	Bla	ck, White,	
36 (13 af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	2 XNo	Specify:		Specia	_{fy:} wh	ite
i / U / D U d 21215-0036 d 21215-0036 lited within 72 hours after deeth with the Maryland Hygiene. ther then "natural; or Itema 23e or 28e-f ehow ont. I'm Medical Evanti ar must be a cultined at	Completed by Funeral Director	15. Decedent's Educa		16a.	Decedent's Usua	l Occupa	tion		16b. Kind of B	Business/In	dustry
715	plet	(Specify only highest grade			(Give kind of wor life. DO NOT us	k done di e retired)	tion uring most of worki	ng			,
With signal	E	Elementary/Secondary (0-12)	College (1-4or 5+)		restaur	ant 1	manager		food	indu	stry
Hygothe other	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Name	(First, Middle	, Maiden Sumai	me)	
ld be ked contained by containe	To B	Mark Snyder					Carme11	a Rina	ldi		
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental Hygiene. F7 is marked other then "natural", or traumatic event. I're Medical Example traumatic event.	-	19a. Informant's Name/Relationship (Type	e, Print)	19b.	Mailing Address	(Street a	nd Number or Rura	I Route Numb	er, City or Town	, State, Zip	Code)
E = 14 F		Francis A. Snyder,	Jr./son	7.	l4 Fairw	ind 1	Drive, Be	el Air,	MD 210	14	
23 19 Baltimore, Marylar bernit. Pages 1 and 2 should b bepariment of Health and Mente mportant: it item 27 is marked nny injury or other treumetic e		20a. Method of Disposition	2	20b. Place of	Disposition (Nam y, crematory or of	ne of		ate	20c. Location	- City or To	own, State
23 19 Baltimore permit. Pages 1 Department of H important: It lies		1 → Burial 2 □ Cremation 3 □ Read 4 □ Donation 5 □ Other (Specify)	moval from State	Dulane	ey Valle	y Mei	m. Gdns.	1/11/2	006 Tim	onium	, Md.
Mit. P. Dortanie ortanie		21. Signature of Funeral Service Licensee			22. Name an	d Addres:	s of Facility				
C W FORES		1/1/1/1					Funeral H				
36		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the	death. Do n	ot enter the mode	Mac. e of dying	Phail Roa y, such as cardiac o	r respiratory a	rrest,	a. 21	Approximate
Playeigier		Immediate Cause (Final									Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a co		n#\-						
Examiner			200 10 (0) 23 2 00	onsequence (21).						
a Property of	er	Sequentially list conditions, if any, leading to immediate cause. Enter unoarrying Cause (Disease or injury	Due to (or as a co	onsequence o	of):						
5929 60, 6	Examiner	Cause (Disease or injury that initiated events									
9, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0,	Exa	resulting in death) Last	Due to (or as a co	onsequence o	of):						
15929	cal	d.									
687 687 g phy as the		0.									2 1 212
CANCIC M \$0.04 Records, P.O. Box 68' The law requires that the death certificate at the assert sequence by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of p						23d. Da	ate of deliv	erv
Boath death of for	cla	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim		3 ☐ Ectopic pro 5 ☐ Other (sp.					onth	Day Year
P.O.	hys	9 Unknown	9□ Unknown								
S, P es that igned be deta	by P	Part II. Other significant conditions conti	ributing to death but n	ot resulting in	the underlying ca	ause give	n in Part I.	23e. Did	tobacco use con	tribute to t	he cause of death?
Records, he law requires to shas been signed ge 2 should be		SPCOLONARY AR	TURY BYPA	455 50	25027			1 🗆	Yes 2□No	3 🗌 Prot	pably 4 Linknown
Cord: Cord: W require should b	lete	CANCER Presheli			, ,			24a. Was	an 24b	Were auto	ppsy findings available
TAMICI	Completed							auto perfe	psy ormed?	prior to co death?	mpletion of cause of
Vital F	ပိ	25. Was case referred to medical	~					1 Yes		1 🗆 Yes	2 No
of Vital	o Be	examiner?	spital:	2 2 R/Ou	tpatient 3 DO	Othe	26. Place of Death				, ,
der on of Jing Phys After this tuneral di	-	27. Manner of Death				8c. Injury	4 Nursing Hor		how injury occu		(y)
After After	tlor	1 Accident 5 Pending investigation	28a. Date of Injury (Month, Day Ye	ear) Ir	njury M	Work			,		
Division To Attending after death. Director: After Tin by the tune	Certification;	3 Suicide 6 Could not be	28e. Place of Injury	- At home, fa	rm. street, factory			28f. Location	Street and Num	ber or Rura	al Route Number,
Div Juin b	erti	4 Homicide	building, etc. (3	Specify)	, ,	,			wn, State)		
Spita nours		29a. Certifier 1 ☐ Certifying Physi	cian: To the best of m	ny knowledae	, death occurred	at the tim	e, date and place	and due to the	cause(s) and m	anner as s	stated.
Division of Vital Re Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	dlcal	(Check only 25) Medical Examine one)	er: On the basis of ex- and manner stated	amination and	d/or investigation,	in my op	inion, death occurr	ed at the time,	date and place	and due t	o the cause(s)
ro th Mithin To th	Me	29b. Signature and title of certifier			290	. License	number		29d. Date signi	ed (Month,	Day, Year)
		Manushin	1	M.	13. 1) 21	809		142	TIL ,	
		30, Name and address of person who con	npleted cause of death				- 1		3.7.0	1	000.
V		G.S. PLABHO M			-	1007	MONIOM	140	21592		
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's		- 69						
Registra		JAN 1 0 20	06 Sallean	1 1	ROUNE	9					

		1 - For State Registrar	-	d / Department of Certificate of		R	2 0 0 0 leg. No.	00333
Physic		1. Decedent's Name (First, Middle, La	Smith			2. Date of Dea Month	PDay Year	3. Time of Death 7:45 M
/Med Exam		4a. Facility Name (It not institution, gin Joseph Riche	Hospice, In		or Location of Death		4c. County of Deal	h
Funera Directo			Sex 1 X M 2□F 7. Age (In yrs. II 5 2	Ast birthday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day)	(Year) Co	hplace (State or Foreign untry)
faryland	or	10a. State 10b. County		. Town or Location				10d. Inside City Limits 1 Yes 2 □ No
with the M se or 28e-f	Funeral Director	Maryland 10e. Street and Number 1708 N. Wolfe		10f. Zip Code	21213	0 1	Og. Citizen of What Co	untry?
1715-60036 within 72 hours after death with the Maryland ene. then "natural; or Items 23a or 28e-f show he Madical Exorther must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
CI 21215-0036 filed within 72 hours af Hygiene. wither then "natural", or out, the Medical Exorn	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retil Curtain Mo	ne during most of work ired)	sing	16b. Kind of Business	industry
be file	To Be C	17. Father's Name (First, Middle, Las Walter Smith)		18. Mother's Nam		Maiden Surname) ~ e.	
C = '' =		19a. Informant's Name/Relationship Terraine Kelly	, Daughter	19b. Mailing Address (Stre	ton St, [Baltime	ore, Md.	21216
Pages nent of ant: If it		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 [4 □ Donation 5 □ Other (Special Service Lice)	Met	lace of Disposition (Name of emetery, crematory or other place of the Crematory or other place)	Inc 1/1	0/2006	•	re, Maryland
Depentition of the porter of t		21. Signature of Puneral Service Lice	nsee ,	_			•	uneral Home, aryland 21215
death certificate be executed death certificate be executed e attending physicien and of for use as the burial-transit	Ical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) c. Due to (or as a consequence) d.	ence of):				Onset and Death
de de de	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic pregnar			23d. Date of del Month	ivery Day Year
HECOLOS, I he law requires the e has been signed ge 2 should be de	Completed by Pt	Part II. Other significant conditions	contribution to death but not result in the contribution of the co	ulting in the underlying cause (given in Part I.		in 24b. Were au prior to death?	obably 4 Donknown
T VITAL IN INSIGNATION IN CONTRIBUTION OF THE	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Deal			11/2 414 4
_ 50 50 50	atlon: To	1 Yes 2 No 27. Man r of Death 1 1 atural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Year)	28b. Time of linjury 28c. In		ome 5 Reside 28d. Describe ho	ence 6 Lother (Spe ow injury occurred	city) HOMILE
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could in determined		ome, farm, street, factory, offic	CB	28f. Location (St City or Town	treet and Number or Ru n, State)	iral Route Number.
Hosp. 24 hou Funer etally fill	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my kno- miner: On the basis of examinat and manner stated.	wledge, death occurred at the tion and/or investigation, in my	time, date and place, y opinion, death occur	and due to the cared at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
To th within To th	Me	29b. Signature and ritle of certifier	Marse 1	29c. Lice	13012	2	9d. Date signed (Mon	Day, Year)
\		John Tayne	completed cause of death (trem	Ver alord To	A Dal	40, M	1/2/2/	2
S Regis	tate trar	31. Date filed (Month, Day, Year)	32 Registrar's Sigha	ture Appare			,	

			•	1- State of Marylan		artment of H		Mental Hy	giene	16	00334
	\$5	Physicia	an	Decedent's Name (First, Middle, Last)		HEFFY		2. Date of De Month		Year	3. Time of Death
		/Medic	al			4b. City, Town, or	Leasting of Doot	Januar		006 by of Death	0045 ^M
	\$.50 +20 100 100 100 100 100 100 100 100 100 1	Examin	er	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Cente	r	Bel Ai				rford	
		Funeral	7.7.	5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth	9. Birth	place (State or Foreign intry)
		Director		170-32-7971 1 ^{1 M 2} F 65	Yrs.	World Suys	110010	Feb. 8	, 1 940	Penr	nsýlvania
		land ow		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
		within 72 hours atter death with the Maryland ane. then 'natural', or itema 23a or 28a-f ehow the Madical Examiner mutal be notilled at	ctor	Maryland Harford Bel	Air						1 ☐ Yes 2X No
		or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Col	untry?
		a 23a	eral	503 Camelot Drive 11 Marital Status 12. Was Decedent Ever in U	S 13	21015 Was Decedent of H	lispanio Origin? (9	Specify Ves or N	USA	ace - Amer	ican Indian,
	(0	r item diner	Funeral	Armed Forces? 1 Never Married 2 XMarried 1 Yes 2 No		If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	ВІ	ack, White	
	036	ours a	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	And Andrews	1 ☐ Yes 2 ☐XNo	Specify:		Spec	ify: Wh	nite
5	15-("natu	lete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	erking	16b. Kind of	3usiness/I	ndustry
700	21215-0036	l within iene. r then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		incipal	•/		Priva	te Ed	ducation
0		be tiled tal Hygi d other	Bec	17. Father's Name (First, Middle, Last)		-	18. Mother's Na	me (First, Middle			
	ylaı	ould b Menti Marked	To	Edward M Kell			Pearl	Agne		titze	
9	Maryland	d 2 sh th and 7 Is m traum	1 8	19a. Informant's Name/Relationship (Type, Print) Donald H. Sheffy — Husband	1	ng Address <i>(Street</i> Camelot Di					
0	e,	Health tem 27 other tr	1	20a Method of Disposition 20b.	Place of Dispo	osition (Name of matory or other place		Date	20c. Location		
-	OE.	Pages nent of int: If Its iry or o		1 V Burial 2 Cremation 3 Hemoval from State		Christiar		13/06	Joppa,	Mary	/land
<u> </u>	Balti	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryla. Department of Health and Mantal Hygiene. Department of Health and Mantal Hygiene. Importants: If item 27 Is marked other then "natural", or itema 23s or 28s-1 ehow eny lojury or other traumatic event, Ite Madical Examinar multi be notified at annote.		21. Signature of Funeral Service Licensee		2. Name and Addre		McComas			•
	5			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.						I) 21(Approximate Interval Between
		Fnysician		Immediate Cause (Final disease or condition	aden	ocarcino	ma	no tacto	tic.		Onset and Death
+		/Medical Examiner		resulting in death) Due to (or as a consecutive death)	juence of):).	10010			
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39	V	uted d ansit	Examiner	Sour tally list conflicts if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
-800439184	,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consec	quence of):						
000	8760,	cate phy:	dlcai	d		*					
#	9 xo	leath certifi attending I I tor use as	clan/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant					23d. C	ate of deli	verv
3	B.	death e atter	Iclar	in the past 12 months? 1 Ves. 2 No. 4 Pregnant at time of		Dectopic pregnancy Other (specify)	/			fonth	Day Year
	P.0	that the de led by the a detached t	Physi	9 Unknown				1			
Jane	ecords,	Se C 6	Ď	Part II. Other significant conditions contributing to death but not re	sulting in the c	underlying cause giv	ven in Part I.		tobacco use co Yes 2 XNo		the cause of death? bbably 4 Unknown
13	000	aw requir as been si 2 should	Completed					24a. Wa	s an 24b	. Were au	topsy findings available completion of cause of
1)_	. E	The lav	Com					per 1 Yes	formed?	death?	2 No
7	Vita	ician; Th certificate rector, pag	Be	25. Was case referred to medical examiner?		! O#	200	eath Check only			
4	to	ding Physician: The n. After this certificate hit tuneral director, page	7. To	27. Manner of Death 28a. Date of Injury	ER/Outpatie	111 30 DOX	4 🔲 INUISING	Home 5 Res	on tow injury occ		cify)
2	ion	nding ath. r: Afte e fune	atio	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury		rk? Yes 2∏No				
5	Division	l or Attendate after death Director:	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At 1 building, etc. (Spec	iome, farm, st	treet, lactory, office		28f. Location City or To	(Street and Nur own, State)	nber or Ru	ral Route Number,
		To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director Affer this certifical completely filled iny the funeral director.	edicalC	Check only one) 2	owledge dez ation and/or i	th occurred at the transcription, in my conventigation, in my convention in the convention of the conv	me data and place	a and dua to the curred at the time	a causa(s) and , date and place	and due	ctated to the cause(s)
		To the within To the comple	Med	29b. Signature and title of certifier		29c. Licens	se number		29d. Date sign	ned (Monti	h, Day, Year)
		/) Home us		D3	6425	MD	1	9/06	
		5			ine	Bel Air	- MD 2	1014			
		St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Refisitar's Sign JAN 1 0 2006	ature	freek					

			1 - For State Registrar	State of M	aryland	/ Depa	artmer rtificat	nt of H	ealth a Death	and Me		giene ()	06	003	35
1	Physicia		Decedent's Name (First, Middle, La JULIA THELMA		CAFFA						2. Date of Dea Month Januar	Day	2006	3. Time of 9:35	
4	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location o		JULIU I		ty of Death	7.33	
			Northwest Hospit	al Center			Ra	ndal]	Lstown	n		Bal	timore	9	
	Funeral		Social Security Number 6. S	6ex 7. A	ige (In yrs. las		If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h v. Year)	Cou	place (State ontry)	or Foreign
	Director		218-01-0954 Supplies the Usual Residence of Decedent		89	Yrs.					Dec. 13	, 1916	Mary	Tand	
	land		10a. State 10b. County		10c. City, 7	Town or Lo	ocation							10d. Inside C	ity Limits
	Man	tor	Maryland Baltim	ore	Pi	ikesv.	ille							1 ☐ Yes	2X No
	or 284	Director	10e. Street and Number				10f. Zi	Code				10g. Citizen o	f What Cou	ntry?	
	23a	ain	8909 Reisterstow	n Road				21	208			U.S	5.A.		
	tems	by Funerai	11. Marital Status	12. Was Deceder Armed Forces	?	13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spec i, Puerto F	cify Yes or No- Rican, etc.)	14. R	ace - Americack, White,		
36	rs afte	y F	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	_		1 🗆 Yes	2 No	Specify:			Spec	eify: T.TL	nite	
0	within 72 hours after death with the Maryland ene. then "naturel", or Items 23s or 28s-f ehow the Medical Exam the could be notified at		15. Decedent's E	ducation		16a. Dece	dent's Usu	al Occupa	ation			16b. Kind of			
215	hin 72 9. 9n "nu Medi	ple	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4o	(5+)	(Give life.	kind of wo DO NOT u	ork done d se retired	during most)	t of workin	1g			,	
2	giene giene er the	Completed	12 years	- Colloga (1 40		Pay	roll	Supe	ervis	or		Aircr	aft De	efense	
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last,)					18. Mothe	ır's Name	(First, Middle,	Maiden Sumi	ame)		
<u> </u>	Men Marke Marke	ပ္	John Woody Dix						Juli			Cox			
Nai	12 sh h and 7 le m traum		19a. Informant's Name/Relationship (Diana Walsh (Type, Print) (granddau)			-				Route Numbe	r, City or Tow rks,M			152
	1 and Healt em 2		20a, Method of Disposition	granddau	20b. Plac	ce of Dispo	sition (Na	me of	1		ate Dpa	20c. Location			172
<u>o</u>	ages ant of it: If if		1 N Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cem	netery, crei	matory or o	other plac	ndens	1-10	0-06	Timoni			4
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or items 23s or 28s-f show early injury or other traumatic event, the Medical Examination at a page.		21. Signature of Funeral Service Licer		Danai								•	il y Lain	.1
ä	Per Per Per Per Per Per Per Per Per Per		George I Fr	mune	_	M	itche 5500	II-W. York	ledei Road	eld i Ral	Funeral Ltimore	Home, Marv	Inc. land 2	21212	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	ed the death.									Approximat Interval Bet	e ween
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100	/Medical		resulting in death)		SEPS is a conseque										
A .	Examiner	_	Sequentially list conditions,	b	RA 10	BDE -	win	7-6	12	rec	teen				
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/_	icate be executed physician and s the burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or a	is a conseque	nce of):		-			_		-		
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9	tificat g phy as th			_ 0.											
Вох	The law requires that the death certific tie has been signed by the attending plage 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnanc		∃Ectopic p	regnancy					Date of delive	ery	
П	o deal	sicis	in the past 12 months? 1 ☐ Yes 2 ☑ No		at time of deat		Other (s)					, A	Jonth	Day '	Year
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Ś	res th	ò	Part II. Other significant conditions		but not resulti	ing in the u	inderlying	cause give	en in Part I.			obacco use co ∕es 2□No			nknown
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Rec	has ge 2 s	id H	The stermen	25 Des	2756						24a. Was autop	an 24b osy rmed?	Were auto prior to co death?	psy findings mpletion of	available duse of
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Division of Vital Record	Physician: r this certificanal director, I	To Be	examiner?	Hospital:	tient 2 🗆 🖂	P/Outpatier	nt 3 D	Oth	25		(Check only only only only only only only only		the Cond	£.,	
o	g Phy er thii		27. Manner of Death	28a. Date of Ir		8b. Time o		28c. Injun Worl			8d. Describe h			у)	
joi	Attending ir death. ector: After by the fune	atio	1 Matural 5 Pending 2 Accident investigatio	n	zay rear)	Injury	М		Yes 2 1	No					
ĬŠ.	r Att ter de irecton n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of	njury - At hom etc. (Specify)	e, farm, str	reet, factor	y, office		2	8f. Location (S City or Tox	Street and Nur vn, State)	nber or Rura	al Route Num	ber,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2									[
	To the Hospital within 24 hours a To the Funeral completely filled	edicai	29a. Certifier 1 Certifying Pl (Check only 2 Medical Examone)	hysician: To the be	of examination	edge, deat n and/or in	h occurred vestigation	at the time, in my of	ne, date and pinion, deat	d place, a th occurre	nd due to the old at the time,	cause(s) and r date and place	manner as s a, and due to	tated. o the cause(s	;)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner	J. (100.		29	c. License	number			29d. Date sign	ned (Month,	Day, Year)	
	- 5 - 0			and -	Ruj))		7	9.50	2		_			26
	3		30. Name and address of person who	completed cause o	f death (Item 2	(Type.	Print)		K	100 =	al in 1 de	y Jen		4 0.	- 4 ,
			ORIANDO B	CONA	-NHN	Fe	9		Rt	4.4.0	4 wester	IN IN	Spores C	stard o	21/32
	Sta Registi		31. Date filed (Month, Day, Year)	32 Regi	strar's Signatur	re An	we		- /						
	TEGIST	reli .	1/1/1/1/1/2	1111D 1 2 26 26 26 2	Marie Care	6									

			1_ For		partment of Health and M	•	_	00336
			Registrar		ertificate of Death		. No.	9 0 0 0
	Physici	an	Decedent's Name (First, Middle, Las	•		2. Date of Death Month	Day Year	3. Time of Death
W. 1	/Medio		Robert Clif			1-6-20		12:37 A ^M
	Examir	er	4a. Fecility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Deat	
			8094 Quarterfield		Severn v) If Under 1 Year If Under 24 Hrs.	O. Data of Birth	Anne Arur	
4	Funeral		5. Social Security Number 6. Security Number 112-44-5689	FM 2□F	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birt	hplace (State or Foreign untry)
	Director		Usuel Residence of Decedent	61 Yrs.		12-12-19	944 MI)
	yland Now		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Man 1-1-sh	to	MD Anne Aru	ndel Severn				1 Yes 2 No
	h the	Irec	10e. Street and Number		10f. Zip Code	100	. Citizen of What Co	untry?
	th will	alD	8094 Quarterfield	Road	21144	υ.	S.A.	
	dea dea	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No-	14. Race - Ame Black, White	
98	or It	Y.F.	1 Never Married 2X Married	1 ☐Yes 2 P No	1 ☐ Yes 2 ☒ No Specify:	, ,		White
21215-0036	72 hours after death with the Maryland natural; or Items 23s or 28s-f show dical Examinar must be natified at	Completed by Funeral Director	3 Widowed 4 Divorced	Year or Dates:				
5	"nat	lete	15. Decedent's Ed (Specify only highest gra-	de completed) (Gir	cedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired)	ring 16	b. Kind of Business/	Industry
12	within ene. then	E G	Elementary/Secondary (0-12)	College (1-4or 5+) Maso			Masonry	
	Hygid Hygid Sthar	ပ္	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma		
an	buld be Mental arked o	To Be	Harry Smith		Beulah	Hackett		
<u>~</u>	2 should and Men is marke	-	19a. Informant's Name/Relationship (7	Type, Print) 19b. Ma	iling Address (Street and Number or Rur		City or Town, State, 2	Zip Code)
Z	nd 2 lith a 27 is r trat		Mrs. Shirley Smit	h / Wife 8	094 Quarterfield R	d: Severn	MD 2114	4
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23e or 28e-1 ehow other traumatic event, the Madical Exertifier main be notified at	. 11	20a. Method of Disposition	20b. Place of Dis			c. Location - City or	
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra-		PEYBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Memoral mont State	ren Memorial Pk 1-	10-2006	Glen Burn	ie. MD
=	mit.		21. Signature of Fyndral Service Licen		22. Name and Address of Facility Sin			
ä	Depa Impo any ii		1 / X XX	Maiso	1 Second Ave SW; G			
			23. Fart1. Enter the disease, or comp	plications that caused the death. Do not e	enter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Physician		mmediate Cause (Final disease or condition	n. L. la	t Lun (un			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):	y sulfer.	CTI		Lmos-
	Examiner		Sequentially list conditions	b)			
-	₽ ≒	ner	Sequentially list conditions, if any, leading to immediate cause. Enter the deriving Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence of):				
760,	be ex cian burial	cal E		Due to (or as a consequence or).				
687	physis the			. d				
χe	certificat Iding physise as th	Physician/Medi	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of del	non.
Вох	death e atten ed for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal death 3	B Ectopic pregnancy Doubler (specify)		Month	Day Year
o.	the d by the ached	ıysı	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown				
a	that ed b deta	y P	Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	een sign	d by				1 Yes	2 □ No 3 □ Pr	obably 4 Dünknown
OS .	law rec as bee 2 shou	Completed				24a. Was an	24b. Were au	topsy findings available
Re	slcian: The law certificate has t rector, page 2 s	E C				autopsy performe	d? death?	completion of cause of
Vital	ifficat	BeC	25. Was case referred to medical		26 Place of Deat	1 ☐ Yes 2 ☑ th (Check only one)	No 1 □ Yes	2 1 No
>	Physician: The l this certificate har al director, page	To B	examiner? 1 D Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpat	Othor		ce 6 □Other (Spec	cify)
9	g Phys er this eral di		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time	of 28c. Injury at	28d. Describe how		,,
<u>io</u>	ath. r: Aft	atlo	1 Accident 5 ☐ Pending 2 ☐ Accident investigation		M 1 Yes 2 No			
Division of	er dei	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre- City or Town,	et and Number or Ru	ıral Route Number,
ā	rs afte al Dii	Certification;		Building, sto. (appeary)		ony or rount,	Sidio	
	lospi houl unar		29a. Certifier 12 Certifying Ph	ysician: To the best of my knowledge, de niner: On the basis of examination and/or	ath occurred at the time, date and place,	and due to the cau	se(s) and manner as	stated.
	the H in 24 the F the F	Medical	one)	and manner stated.				
	To the Hospital or Attending Phys within 24 hours after death. To the Funaral Director: After this completely filled in by the funeral di	2	29b. Signature and title of certifier	1/1/	29c. License number	290	. Date signed (Monti	h, Day, Year)
	ĺ		1/10/	111	()'S/55	1	1904cm1	6,2006
	W		30 Name and address of person who	completed cause of death (Item 23a) (Typ	e, Print)		0 11	211/27
			31. Date filed (Month, Day, Year)	Jacobson DO	1 HOSPITAININ	t, (-/82)	Dym) M.	21001
	Sta Regist	ate rar	IAM 1 A 2	32. Registrar's Signature	back	•		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 8:40 AM **Physician** January, 4m 2006 Marjorie Markn Smiln /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore, MD. Medical Center City Mercy If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Feb 5, 1921 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 84 Yrs. Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nand of Health and Mantal Hygiene.
and: if them 27 is marked other than 'naturel', or items 23s or 28e-1 ehow ury or other treumsite avent, its Madical Examinating the indities in 1 X x 2 □ No MD N/A Completed by Funeral Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a filed within 72 hours after death with in Hygiene. 524 N. Charles Street Apt. 200 21201 U.S.A. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 💹 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXVo 3 ☐ Widowed 4 X Privorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Baltimore City 12 +17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk. unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Laura Fick / Executor/Friend 4137 Roland Avenue Baltimore, MD_ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Kremation 3 Removal from State permit. Page Depertment of Important: If eny injury or Metro Crematory 01/06/06 4 □ Donation 5 □ Other (Specify) Catonsvillle, MD 21. Signature of Funeral Service Licenses Burgee-Henss-Seitz Funeral Home, Inc. 23a. Part1. Efter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia IWECK **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): physicien a s the burial-Box 68760. Physician/Medical SB IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ŏ in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Ď 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 2 No 1 Yes certificate 1 Yes Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA siqu 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) 30 | St. Paul 32. Begistrar's Signature Pl., Baltimore, MD 31. Date liled (Month, Day, Year) State Registrar

ORIGINAL

			1 - For State Registrar	State of Marylan		artment of H rtificate of I		Mental Hygie	/11116	00338
	Physici /Medic	- 6	1. Decedent's Name (First, Middle, Last) Robert M. Selb					2. Date of Death Month	Day Year 5 2006	
	Examin	er	4a. Facility Name (If not institution, give Union Memorial	Hospital			timore			N/A
- e	Funeral Director		5. Social Security Number 6. Security 15 15 15 15 15 15 15 15 15 15 15 15 15	7. Age (In yrs.)	Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi			rthplace (State or Foreign ountry) ryland
	Maryland a-f show	tor	10a. State 10b. County Maryland N/A	10c. Cit	y, Town or Lo Balti					10d. Inside City Limits XXX Yes 2 ☐ No
	ath with the 23e or 28	rai Dire	10e. Street and Number 4020 Falls Road			10f. Zip Code	21211	10g.	. Citizen of What C	ountry?
396	perruit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deptiment of health and Mental Hygiene. Deptiment of Health and Mental Hygiene. Inportent: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic avant, the Medical Exam, per must be notified at one.	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2∑No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2€€No	ispanic Origin? in, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi Specify:	
Baltimore, Maryland 21215-0036	ithin 72 hound.	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of w ()	rorking	b. Kind of Business	
and 21	d be filed w antal Hygier asd other th c svant, th	Be	12 17. Father's Name (First, Middle, Last) Robert M. Selby,	Sr.	Claim	s Represe	18. Mother's N	So ame (First, Middle, Mai egina Lang	,	urity
Maryl	nd 2 should alth and Me 27 is mark	Τo	19a. Informant's Name/Relationship (Ty				and Number or i	elton, Penr	ity or Town, State,	
more,	Pages 1 a nent of Hea ant: If Item ary or othe		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ R 4 ☐ Donatjon 5 ☐ Other (Specify)	emoval from State	emetery, crer	sition (Name of natory or other plac rematory			atonsvil	
Balt	Departi Departi Importi any inj		21. Sign tury of Funeral Service License	Henss	Bi 30	Name and Address urgee-Hen 531 Falls	ss of Facility SS-Seit Road,	z Funeral H Baltimore,	Home, Inc Maryland	. 21211
	Compared to the process of the proce	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	/ /	uence of):	Failure	g, such as cardi	ac or respiratory arrest.		Approximate Interval Between Onset and Death Week
.O. Box 68760,	The law requires that the death certificate be site has been signed by the attending physicic page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of di	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	llivery Day Year
۵.,	w requires that been signed b should be deta	ρ	Part II. Dther significant conditions cor	ntributing to death but not rest	ulting in the u	nderlying cause givi	en in Part I.	23e. Did tobac		o the cause of death? robably 4 Unknown
l Reco	icien: The law re certificete has be ector, pege 2 sho	Completed					-	24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Division of Vital Records,	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	ertification: To Be	27. Manner of Peath 1 Hural 5 Pending 2 Accident investigation	lospital: 1 / Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun World	er: 4 🗌 Nursing	eath Check only one Home 5 Residence 28d. Describe how		ocify)
<u>X</u>	bitel or Attures after de sel Directuilled in by t	O	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	<i>(</i>)			28f. Location (Stree City or Town, S	itate)	
	o the Hosp ithin 24 ho o the Func ompletely f	Medical	29a. Certifier (Check only one) 2 Medical Exami 29b. Signature and title of certifier	ner: On the basis of examina and manner stated.	whadge death tion and/or in	vestigation, in my op	oinion, death oc	curred at the time, date	and place, and du	e to the cause(s)
•	10/1		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	AT Print)	24380	146]	anuary 5	, 2006
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Signa	to on 1	Carles	ospilal	MD		

			For State Registrar	State of	of Maryla	and / Depa <i>Ce</i>	artment of F	lealth ar Death	nd Mental Hy	giene Reg. No.		00339
	Dhusisi		1. Decedent's Name (First, Mid	dle, Last)					2. Date of De Month	eath Day	Yea	3. Time of Death
	Physicia /Medic		Jerry	Snead, S	Sr.				January		2006	2:30 A. ^M
	Examin		4a. Facility Name (If not institut	-	um <i>ber)</i>		4b. City, Town, o	r Location of I	Death	4c.	County of De	
			543 CrossBrid	<u> </u>			Westmins				Carro1	
	Funeral		5. Social Security Number	6. Sex 1 M 2 ☐ F		rs. last birthday)	If Under 1 Year Months Days		Min. (Month, D.	ay, Year)		Birthplace (State or Foreign Country)
	Director		217-26-1654	X	76	Yrs.			November	01,	1929	Maryland
	and w	1	Usual Residence of Decedent 10a. State 10b. Cour	ity	10c. (City, Town or Le	ocation					10d. Inside City Limits
	ours after death with the Marylan ret', or Items 23e or 28e-f show Exacilier must be notified at	ō	Maryland Car	roll	W	estmins	ter					1 ☐ Yes 2 ☑ No
	28e-	ect	10e. Street and Number				10f. Zip Code			10g Citi	zen of What	Country?
	with 6 or	ä	543 CrossBri	den Pond				0	-	-		
	eath	Funeral Director	11. Marital Status		cedent Ever in	U.S. 13	21158 Was Decedent of H					es of America
	iter d	필	1 ☐ Never Married 2 ☐ M	Armed F	orces? 200 No		If Yes, specify Cuba	an, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)		Black, WI	
9	urs a	by	3 Widowed 4 □ Divorc	If Yes G	ive		1 ☐ Yes 🌠 No	Specify:			Specify: W	hite
5-0036	n 72 hours after death with the Maryland "naturel", or Items 23e or 28e-f show alone Exacilizer must be notified at	Completed		ent's Education			dent's Usual Occup			16b. Ki	nd of Busines	ss/Industry
_	within 7 ene. than "n r Mad	pie	Elementary/Secondary (0-12	hest grade completed	(1-4or 5+)	life.	kind of work done DO NOT use retired	d)	or working		_	
2121	filed withi Hygiene. other than ent. It e M	No.	12	0	(, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Bulla	ing Super	.		rede	ral Go	vernment
	othe vent	Be C	17. Father's Name (First, Middle	e, Last)				18. Mother's	s Name (First, Middle	e, Maiden	Sumame)	
<u>a</u>	Aents Aents rked tice	To E	John Sn	ead				Emily	7 Deshiel	.ds		
Maryland	s 1 and 2 should be filed within 72 hr I Health and Mental Hygiene. Item 27 is marked other than "natur other treumstic event, Ite Musical		19a. Informant's Name/Relatio	nship (Type, Print)		19b. Maili	ng Address (Street	and Number	or Rural Route Numb	oer, City o	r Town, State	a, Zip Code)
Σ	alth alth 27 i		Jerry Snead,	Jr.	(Son)	543 0	rossBride	re Road	l Westmin	ctor	Mary	1and 21158
ē.	iterr oth		20a. Method of Disposition		20b	Place of Disponent	osition (Name of matory or other place	ce)	Date	20c. Lo	cation - City	1and 21158 or Town, State
Ë	Page ent c nt: If ry or		1 ☐ Burial 2 Trematio 4 ☐ Donation 5 ☐ Other		Jule		ematory	1	1/06/06	Ra1	timore	, Maryland
Baltimore,	permit. Pages 1 and 2. Department of Health at Importent: If item 27 is any injury or other treuonce.		21. Signature of Funeral Servi	e Licensee								Directors, In
ä	permi Depar Impo any ir		1/37. Juse	>								yland 21133
			23a. Part1. Enter the disease,	or complications that	caused the de						· · · · · · · · · · · · · · · · · · ·	Approximate
	Physician :		shock, or heart failure. L Immediate Cause (Final	st only one cause on	each line.	000) W (A				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	o (or as a cons	conneuca ott.	,00					5 mil
=	Examiner			Due to	O (OI as a COIIs	equence or,						
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	o (or as a cons	sequence of):						1
/	uted d ansit	dical Examiner	Cause (Discase of migury	1								
,	be executed iician and burial-transit	Exa	that initiated events resulting in death) Last	C. Due to	o (or as a cons	sequence of):						
8760,	ate be executed hysician and the burial-transif	cal										
68												
Вох	death certifica e attending ph ed for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pre		7				23d. Date of c	delivery
m	d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2 ☐ Fi gnant at time o		⊒Ectopic pregnancy ☐ Other (specify) _	y 			Month	Day Year
0	the c by the acher	nys	9 Unknown	9□ Unki	nown							
σ,	w requires that the death cer been signed by the attendin should be detached for use	y P	Part II. Other significant cond	itions contributing to	death but not i	resulting in the o	inderlying cause giv	en in Part I.	23e. Did	tobacco u	ise contribute	to the cause of death?
ds	puires n sign	q p							1 🗆	Yes 2	□No 3□	Probably 4 Chiknown
Records,	w red beer	Completed by							24a. Wa	s an	24b. Were	autopsy findings available
Re	The law sate has b page 2 sl	шú							auto	opsy ormed?	prior t death	to completion of cause of
	lcien: Th certificate rector, pag	e C	25. Was case referred to medi	cal				00 Disease	1 Yes	2 140	1 DY	es 2 No
of Vital	iding Physicien: 'th.' After this certifica funeral director, p	8	examiner?	Hospital:	Inpatient 2	! ☐ ER/Outpatie	nt 3 DOA Oth	205	of Death (Check only	-	2 []01 (0	
of	Phy r this ral d	1: To	27. Manner of Death				III JU DOX	4 🗀 19015	ing Home 5 Res			рөсіту)
O	ding h. Afte fune	tior	1 ☑Natural 5 ☐ Pen 2 ☐ Accident inve	ding (Mo	e of Injury onth, Day Year) Injury	Wor	rk? ∣Yes 2.⊟No			,	
S	Attending r death. ector: After y the fune	fica	3 ☐ Suicide 6 ☐ Cou	14 15 -	ce of Injury - A	t home, farm, st				(Street an	d Number or	Rural Route Number.
Division	after Dire	Certification:	4 Homicide dete	ermined build	ding, etc. (Spe	ecify)	reet, factory, office			wn, State		All All All All All All All All All All
	spite ours nerel filled		29a. Certifier 1 Certif	ying Physician: To th	ne best of my l	knowledge des	th occurred at the tir	me data and	place, and due to the	A Causa(s)	and manner	as stated
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only 2 Medic	al Examiner: On the	basis of exam inner stated.	ination and/or i	rvestigation, in my o	ppinion, death	occurred at the time	, date and	I place, and d	due to the cause(s)
	o the	Me	29b. Signature and title of cert				29c. Licens	se number		29d. Dat	e signed (Mo	onth, Day, Year)
	F 3 F ŏ		HALLAND	Kurk	1 h	D	Net	795	7			5-0B
	1.		20 Name			1 400 mm mm m	ג ברעה	1712				
	り		30. Name and address of pers	11) 55	use of death (I	tem 23a) (Type		11.7	Stmuster	11	1115	
	- 01		31. Date filed (Month, Day, Ye		Registrar's Sig	gnature	EL DU ET	y W	2111117716	, LID	2110	/
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			For State Registrar		State of	of Ma	ryland	-	artment of rtificate o			nd M		iene	006	0034	0
			1. Decedent's Name (First, Mi	idle, Last)									2. Date of Dea	th		3. Time of Deat	th
	Physicia /Medic		ARTHUR O.	STEE	NBURG								Month JANUARY	. Bay	2006	11:00 P	М
}	Examin		4a. Facility Name (If not institu	ion, give s	treet and nu	umber)			4b. City, Town	, or Lo	ocation o	f Death			County of Death		
П		ż	PICKERSGILL F	ETIR	EMENT	COM	MUNITY	<i>r</i> 	TOWSO	N				В	ALTIMORI	Ŧ)	
	Funeral		5. Social Security Number	6. Sex	M 2□F	7. Age	(In yrs. last		If Under 1 Year Months Day		f Under 2 Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or For	eign
Ь.	Director		215-05-3598	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1101 201		94	Yrs.					11/27/	191	1 FLO		
	and w	1	Usual Residence of Decedent 10a. State 10b. Cou	ity			10c. City, T	own or Lo	cation		-					10d. Inside City Lin	nits
	Maryl f sho	ō	MD BA	LTIM	ODE		7	VIJCO	N T							1 ☐ Yes 2 🔀	No
	the 288-	le C	10e. Street and Number	T T T 1/3/	ORE			OWSO	10f. Zip Code	9		-		0a. Citi:	zen of What Co	untry?	
	3e or		1627 HARDWICK	DOM:					0.1	006							
	death ms 2	Funeral Director	11. Marital Status		12. Was Dec	cedent E	ver in U.S.	13.	Was Decedent of	286 of Hispa	anic Orig	in? (Spe	cify Yes or No-		USA 14. Race - Amer		
9	or Ite	F	1 Never Married 2 N	arried	Armed F 1X Yes If Yes, G Year or I	orces?	ိုဂ္ဂ		If Yes, specify C			, Puerto F	Rican, etc.)		Black, White	e, etc.	
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28a-f show to Medical Examiliar in 11st for restilled at	d by	3 ☐Widowed 4 ☐ Divord	ed	Year or I	Dates:	1933		1 ☐ Yes 2 ☐xt\	vo .	Specify:				Specify: WI	HITE	
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12	vithin ne. han '	dm	Elementary/Secondary (0-1)		College		+)		DO NOT use ret	-							
	Hygie ther t nt, II		17. Father's Name (First, Midd		4 YEAF	الكاركة		LA	B TECHN			r's Name	(First, Middle,		OSPITAL		
and	be intal i) Be	ARTHUR O. ST		TRC S	SP							TI. HE				
Maryland	should nd Me mark mati	٢	19a. Informant's Name/Relation			2		19b. Maili	ng Address (Stre	et and						in Code)	
Š	nd 2 :		MARY LEE MILI			CR		0290 0	3 PINEW				ALTIMOR				
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23e or 28a-f show eny injury or other treumatic event. It a Modical Examiliar in usi be rediffied at once.		20a. Method of Disposition					e of Dispo	sition (Name of matory or other p		AVE			_	cation - City or		
E O	Page ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other		emoval fron	n State			EMATORY.	,	NC	1/9/	2006	САТҮ	ONSVILLE	T MD	
Baltimore,	mit. Joartm Sortei / inju		21. Signature of Funeral Serv		9e		100									HOME, P.A	
Ö	Deparenti Deparenti Imporenti eny ir					/			521 LOCI							1286	•
		î	23a. Part1. Enter the disease shock, or heart failure.	or compli	ications that	caused	the death. I	Do not en	er the mode of o	tying,	such as	cardiac o	r respiratory arr	est,		Approximate Interval Between	,
	Phy sicia n		Immediate Cause (Final disease or condition	,		1		(t)	ale	(An	Ce	K			Onset and Death	1
	/Medical		resulting in death)		Due to	o (or sa	consequen		,,,,						1	1	
ĕ.	Examiner		Sequentially list conditions	l t	o,												
r.	Po #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	2	Due to	oras a	consequen	ice of):									
10	ecute and I-trans	Examin	cause (Disease or injury that initiated events resulting in death) Last	0	Due to	o (or as a	consequer	ice of):									
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387	icate phys s the	dicai			J												
_	leath certific attending pl	/We	IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, o	utcome	of pregnancy	/							23d. Date of deli	verv	
Box	death atter	Physician/M	in the past 12 months?				2 ☐ Fetal de time of deat		□Ectopic pregna □ Other (specify)						Month	Day Year	
P.O.	that the di ed by the detached	hys	9 Unknown		9□ Unk	nown											
	The law requires that the death certif Ite has been signed by the attending bage 2 should be detached for use ar	by P	Part II. Other significant cond	itions cor	ntributing to	death bu	ıt not resultir	ng in the u	nderlying cause	given	in Part I.		23e. Did to	bacco u	se contribute to	the cause of death	?
Records,	w require been sig should b												1 □ Y	es 25	No 3□Pro	bably 4 Unkno	own
900	e law requ has been je 2 shouk	ompieted											24a. Was a autops		24b. Were au	topsy findings availa	able
Ä	The late has page	E O											perfor	ned? 2. No	death?	2 No	Ų1
Vital	sician: Th certificate irector, pag	Be C	25. Was case referred to med examiner?	ical						2	6. Place	of Death	(Check only or	_			
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 No	F	lospital: 1 [Inpatie	nt 2 ER	/Outpatie	nt 3 DOA	Other:	4 Nu	rsing Hon	ne 5 🗆 Reside	ence (6 □Other (Spec	rify)	
ח	5 0 0 0	on:	27. Manner of Death 1 Natural 5 □ Per	ding	28a. Date (Mo	e of Injur onth, Day	Year) 28	Bb. Time of Injury	V	Vork?			.8d. Describe h	ow injury	y occurred		
Sio		cati	E C / NOVIGORIA	stigation Id not be		4					s 2 🗆 t	-	ar I ii ia				
Division	after dans in by	Certification:		mined	28e. Plac buil	ding, etc	ry - At nome :. (Specify)	e, tarm, st	reet, factory, offic	Ce		2	City or Town			ral Route Number,	
_	spitel lours nerel filled		29a. Certifier ↑ Certi	ving Phy	sician: To th	ne best o	of my knowle	doe. deat	h occurred at the	e time	date and	d place, a	and due to the c	ause(s)	and manner as	stated	
	To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: Att completely filled in by the fun	edicai	(Check only 2 Medi	al Exami	ner: On the	basis of inner sta	examination	and/or in	vestigation, in m	y opin	ion, deat	h occurre	ed at the time, d	ate and	place, and due	to the cause(s)	
	To the within 2 To the complet	Ž	29b. Signature and title of cer	itier	1		0		29c. Lice						e signed (Month		/
)			V/ //	10/1	my	K.	lu	n	m ()-	2:	52	05	1)	Ar	NAN	7,2001	O
	10+1		30. Name and address of pers	on who co	mpl ed ca	use of de	eath (Item 2	Ba) (Type	Print)	1.	0	(3)	En 1	12	mel 2	9,2001	
			31. Date-filed (Month, Day, Yo	ar)	7 6	Ponistr	n (101	1400	LAL		2./		10	,	/	
	Sta Registi		1		32.	registra	ii s aignaidh	-	D. 3								
			JAN 1 0	2005	A STATE OF	Sager	9.6	Sept Land	POSP"								

1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Robert R. Springer, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 8. Date of Birth (Month, Day, Year)
Time 2, 1939 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F 69 216-34-9706 Director Usual Residence of Decedent the Marylan 10c. City, Town or Location 10a State 10b County or items 23s or 28e-f show or other traumatic event, If a Medical Examiner must be nutilised at MD Carrol1 Finksburg Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2525 Baltimore Blvd #19 21048 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Policeman police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any injury or other traumatic event once. Be Albert H. Springer Mary Rutley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2525 Baltimore Blvd #19 Finksburg, MD 21048 Anna L. Springer wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial 1/13/06 Finksburg, MD * 4 ☐ Donation - 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service L 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) VEN TRICLE LEFT **Physician** /Medical Due to (or as a consequence of) **Examiner** CRITICAL AORTIC Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Due to (or as a consequence of)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

3. Time of Death

0449

10d. Inside City Limits

Approximate Interval Between Onset and Death

□ No 3 □ Probably 4 □Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 No

Birthplace (State or Foreign Country)

Baltimore, MD

Amend item#8, perFH 1852, 2/21/06 TT State of Maryland / Department of Health and Mental Hygiene

To the Hospital or Attending Physician; The law requires that the death certificate be executed -transit

RUTLEY SPEINGER

OBERT

and after death.

Director: Af within 24 hours a

To the Funeral C

completely filled i

Division of Vital Records, P.O. Box 68760

Certification: To Be Completed by Physician/Medical Examiner	000
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Zause (Disease or Injury hat initiated events esulting in death) Last	cDue to (or as a consected	quence of):			
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3 □Ectopio	c pregnancy (specify)		23d. Date of delivery Month Day Year
eart II. Other significant conditions of	contributing to death but not re-	sulting in the underlyin	g cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Unkno
ENEU MONIA				24a. Was an autopsy performed?	
25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ER/Outpatient 3☐	Othor	ath (Check only one) Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how inj	jury occurred
3 Suicide 6 Could not b 4 Homicide determined		nome, farm, street, fac	tory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
29a. Certifier 1 ☐ Certifying Pt (Check only one) 2 ☐ Medical Exam	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occum ation and/or investigat	red at the time, date and plac- tion, in my opinion, death occ	e, and due to the cause(urred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title objectifier	21 M.	٥.	29c. License number D 00 54 S		Nate signed (Month, Day, Year)
Name and address of person who WASIM FAK HAR,	completed cause of death (Ite	m 23a) (Type, Print) E BALT	ST#D, TAM	IEY TOWN	MD 21787

DHMH 17 Rev 1/2001

Registrar

32. Raistrar's Signature

JAN 1 0 2006

31. Date filed (Month, Day, Year)

			For State Registrar	State of I	Maryland / I		rtment of H		and Me		iene	06	00342
			Decedent's Name (First, Middle	e, Last)			imodio oi E		2	2. Date of Deat	h	0 0	3. Time of Death
	Physicia		Flmor H	Schaefer						Month January	Day 6	Year 2006	1:10P M
	/Medic Examin		4a. Facility Name (If not institution		er)		4b. City, Town, or	Location o		ranaar y	4c. Count		
	LXaiiiii	:	Manor Care Ru	vton			Towso	n			B	altim	iora
Y	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last bi	rthday)	Il Under 1 Year Months Days	If Under a	24 Hrs. 8	B. Date of Birth (Month, Day,			place (State or Foreign intry)
4	Director		215-26-0548	M 2□F	95	Yrs.	Months Days	Houis		farch 8		300	MD
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow		antin a						10d. Inside City Limits
	anyla shov	2			Toc. Oily, Tow	VII OI LO	zation						1 ☐ Yes 2X No
	he M	Funeral Director	MD Balti	more	Owi	ngs	Mills				On Citizen of	Min at Cau	
	a or S	ä	10e. Street and Number				10f. Zip Code			, ,	0g. Citizen of	what Cou	intry ?
	s 23	era	120 St. Thom	as Lane	nt Ever in U.S.	13 1	2111		nin? (Spec	fy Ves or No-		SA Ca - Ameri	ican Indian,
	Item Item	Ę.	1 □ Never Married 2 □ Marri	Armed Force	s?	13. 1	Vas Decedent of His Yes, specify Cubar	n, Mexican	, Puerto R	can, etc.)		ck, White,	
336	urs af	by F	3 ☐Widowed 4 ☐ Divorced	If Yas, Give		1	☐Yes 21XXNo	Specify:			Specia	fy: W	hite
21215-0036	72 hours after death with the Maryland neturel', or Items 23s or 28s-f show diest Examiret rust be notified at	ted		t's Education		. Deced	ent's Usual Occupa	tion			16b. Kind of E		
21	within 7 ene. than "n	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4)	or 5+)	life. L	kind of work done d OO NOT use retired)	uring most	or working	, i			
21	d wit	TO.	12			Se	exton			;	St. The	omas_	Epis.Church
g	be filed vital Hygie d other is	Be (17. Father's Name (First, Middle,	Last)				18. Mothe	r's Name (First, Middle, N	Maiden Sumai	me)	
Va	Ment Ment arkec	၉	Robert A. Sch	aefer				Ha	nna A	. Franl	ĸ		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 is marked other than "neturel", or items 23s or 28s-f show other treumatic event, the Medical Exemple arms I be notified at		19a. Informant's Name/Relations	hip (Type, Print)	198	b. Mailin	g Address (Street a	nd Numbe	er or Rurai	Route Number,	City or Town	, State, Zip	p Code)
	1 and 3 Health sem 27 other tr		Ruth M. Bradfo	rd Nie			Emory R	oad,				0: -	
altimore,	Pages 1 are neut of Hearn of Hearn of Hearn or it item iry or othe		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from Sta	- comoto	ary, cren	sition (Name of natory or other place	9)	Da	(8	20c. Location	- City or To	own, State
Ë	permit. Pages Department of Importent: If i any injury or one		`4 ☐ Donation 5 ☐ Other (S		St. T		s Cemete		1/10/	2006 _	Owings	s Mil	ls, MD
Ball	permit Depar Impor Impor any in		21. Signature of Funeral Service	Licensee			Name and Addres		. 1	1824 Re			
	403 8 Q		Janos.	Cum			ine Fune					MD 2	
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on eac	sed the death. Do 1 line.	not ente	or the mode of dying	g, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition resulting in death)	a CEK	EBROU	1AS	CHLAR	11	YRO	MBO.	515 3	2	Die
	/Medical Examiner		rosalling in dodiny		as a consequence								2075
		10	Sequentially list conditions,	b	as a consequence		· · · · · · · · · · · · · · · · · · ·						
500	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	7	,-							
_6	be executed sician and burial-transit	хаг	that initiated events resulting in death) Last	c. Due to (or	as a consequence	of):							
8760	ate be ex hysician the burial	ai											
687	ficate p phys	ledicai		u									
Вох	The law requires that the death certificate ten as been signed by the attending physoage 2 should be detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco							23d. Da	ate of deliv	very
	death e atte	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnan	2 ☐ Fetal death t at time of death		Ectopic pregnancy Other (specify)				М	onth	Day Year
0	that the di ed by the detached	hys	9 Unknown	9□ Unknow	1								
٥,	es tha igned be del	ру Р	Part II. Other significant condition		5.5		, ,			23e. Did tob	acco use con	tribute to t	the cause of death?
ğ	w require been sign	ed	(1) Ke	nal fai	lure.					1 TYe	s 2 No	3 Prob	bably 4 nknown
S	e taw requ has been je 2 shoul	Completed	(2) Co	ronary	Artery	17	Disease	_		24a. Was ar		Were auto	opsy findings available empletion of cause of
Ä	The ate ha	mo		/	/	Andrew State of the Local State				perform	ned?	death?	
ita	certifica rector, p	Bec	25. Was case referred to medica examiner?	1				26. Place	ol Death (Check only on			
of Vital Records,	sir dij	10	1 Yes 2 No	Hospital: 1 ☐ Inp	atient 2 ER/O	utpatien	3 □ DOA Othe	1 4 (7) u	rsing Hom	e 5 ☐ Reside	nce 6 □Ot	her (Speci	ify)
	ng Ph fter th ineral	on:	27. Manner of Death 1 Matural 5 □ Pendir	28a. Date of (Month,	njury 28b. Day Year)	Time of Injury	28c. Injury Work	at ?	28	ld. Describe ho	w injury occu	rred	
Sio	Attending r death. ector: After by the fune	cati	2 Accident investi	gation				/es 2 □ 1					
Division	sal or Attending Pl s after death. bl Director: After the in by the funera	ertification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Place of building	Injury - At home, fa etc. (Specify)	arm, str	et, lactory, office		28	If. Location (St. City or Town		ber or Run	al Route Number,
	urs al	O											
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	ledical	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the be Examiner: On the basi and manner	s of examination ar	je, death nd/or inv	occurred at the time estigation, in my op	e, date an inion, dea	d place, an th occurred	d due to the ca I at the time, da	ause(s) and mate and place,	anner as s , and due t	stated. to the cause(s)
	ithin (Med	29b. Signature and title of certifie		stateu.		29c. License	number		2:	9d. Date signe	ed (Month,	, Day, Year)
	F ≥ F 8		· AP	3/1/2 /	1 442				24				
,	(X)		30. Name and address of person	who completed sauce	of death (Item 22-)	Tvoo	Print)		01				-
	D.91		A.H. GHILA	4)/ M/J	7600	(туре,	D-B SLER	DY	· To	WSON	1 11	0 2	21204
A	Sta	ate	31. Date filed (Month, Day, Year)		arar's Signature	-			, -				,
	Regist		JAN 1	0 2006	Reference de	4	Carrie						
						-							

			1 - For State Registrar		State of M	laryland		rtmen: tificate			d Mer	-	gien Reg. Ni	7111)6	003	343
			1. Decedent's Name (F	First, Middle, Las	st)						2.	Date of De Month			Yeer	3. Time	of Death
	Physici: /Medic		Harold V	V. Sine		_						Januar	cy 8	, 20		7:11	IA M
F	Examin		4a. Facility Name (If no	ot institution, give	street and number,)				Location of D	Death		40	c. County	of Death		
E			Montgomery					Roc1	kvill	e If Under 24	Hee la			ontg	-		
	Funeral Director		5. Social Security Num 233-50-302		ex	ge (<i>in yrs. ii</i> 72	ast birthday) Yrs.	Months	Days		Min. M	Date of Bir (Month, Da ay 28	tn iy, Year 1 C	333	Coui		
			Usual Residence of De			12					111	ay 20	, 1	,,,,	west	Virg	inia
	how		10a. State	0b. County		10c. City	, Town or Lo	cation							1	Od. Inside (•
	Sa-1 s	Director	Maryland N	Montgome	ery	Roc	kville	2								1 🗌 Ye	s 2 XNo
	or 28	Dire	10e. Street and Number	ər				10f. Zip	Code				10g. C	itizen of V	hat Cour	ntry?	
	23e		5615 Halp:	ine Road				208			2 (2)			ted			
_	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or iteme 23e or 28e-f show event, the Modical Exambler must be multied at	Funeral	11. Marital Status 1 ☐ Never Married	200 Married	12. Was Decedent Armed Forces 1 XYes 2	?	1 1	Mas Deced f Yes, spec	ent of His of Cuban,	panic Origin , Mexican, P	Puerto Ric	y yes or No an, etc.))-		k, White,	can Indian, etc.	
212-0030	urs af	þ	3 Widowed 4	_	If Yes, Give Year or Dates:		lict	I ☐ Yes 2	No.	Specity:				Specify	Whi	lte	
Ş	2 ho	Completed		5. Decedent's Ed			16a. Deced	dent's Usua	l Occupati	tion	d supplied		16b. l	Kind of Bu			
7	within 72 ene. then "nat	nple	Elementary/Seconda	only highest gra ary (0-12)	College (1-4or	5+)				iring most of							
7	ygien ygien tt, be	Co	12				Shi	ping		erviso				rint			
	be fi	Be	17. Father's Name (Fir							18. Mother's				n Sumam	e)		
Maryland	hould d Me mark matic	ဥ	Not Ava:	ilable	Type Printl		10h Mailie	a Addrace	(Stroot an	darr nd Number o		. Sine		or Tours	State 7ie	Cadal	
<u>8</u>	od 2 s lith an 27 le		Joanna J.							Road,						20851	
ā,	f Healthen		20a. Method of Dispos	sition		20b. Pl	lace of Dispo	sition (Nam	ne of	1_		11,				own, State	
Baitimore,	permit. Peges 1 and 2 should be filed with Depertment of Health and Mental Hygiene, importent: if item 27 ie marked other ther eny fulury or other traumatic event, the MDEs.		1 🖾 Burial 2 🗆 0 4 🗇 Donation 5 I]Removal from State y)	Par	emetery, crer klawn Parl	Memo	rial	20		, 11,	Roc	kvi1	1e. 1	Maryla	and
<u>=</u>	mit.		21. Signature of Fune	ral Service Licer	600		22	. Name an	d Address	of Facility	Rober	rt A.	Pun	phre	y Fu	neral	Home
Ω	8858		1 Ca	في علف	uy,	M008	303 R	ockvi. ockvi.	11e,	Maryl	and	2085	o ^M 28	tgom	ery A	Avenu	5
			23a. Part1. Enter the shock, or heart fa	disease, or com ailure. List only	plications that cause one cause on each	ed the death line.	n. Do not ent	er the mode	e of dying,	, such as ca	rdiac or re	spiratory a	rrest.			Approxima Interval Be	etween
	Physician		Immediate Cause (Fir disease or condition	nal	Panci	reatio	Cance	er								Onset and	J Death
	/Medical Examiner		resulting in death)		Due to (or a	s a consequ	uence of):										
	LAdminier	L	Sequentially list condi	tions.	b		steer on										
,	ted nsit	Examiner	if any, leading to imme cause. Enter Underlyi Cause (Disease or inju	ing -	Due to (or as	s a consequ	dence on):										
	cate be executed physicien and the burial-transit	xan	that initiated events resulting in death) Las		C. Due to (or as	s a consequ	uence of):				-						
8760,	sicier b buri	dical		l	d												
89	g physies the test				u												
ŏ	death certif e ettending ed for use es	an/N	IF FEMALE: 23b. Was decedent pr		23c. If yes, outcome			Ectopic pr	ecnancy						e of deliv		
P.O. Box	deat	sicie	in the past 12 mg		4☐Pregnant a			Other (sp.						Mo	nth	Day	Year
ت آ	iaw requires thet the death certifi as been signed by the ettending 2 should be detached for use es	Physician/M	9 Unknown														
ŝ	res th	þ	Part II. Other significa	int conditions o	onthouting to death	DUI NOI FOSI	uiting in the u	nderlying ca	ause giver	nın Part I.						he cause of pably 4	
Ö	w require been sig should b	Completed								_	-	-		1			
Ş	elaw hast	μ									-	24a. Was	DSV	1 6	Vere auto prior to co leath?	opsy finding impletion of	s available cause of
ē	n: The ficate hย ห. page		05. Was assessed	44									ormed? 2X N	0 1	Yes	2 No	
Division of Vital Records,	Attending Physician: The law ir death. ector: After this certificate has t by the funeral director, page 2 s	o Be	25. Was case referred examiner? 1 ☐ Yes 2 ☑ No		Hospital:	iont 2	ER/Outpatier	nt 3 DO	Other	26. Place of				c Most	(0	y) Hos	nico
ō		n: To	27. Manner of Death		28a. Date of Inj (Month, D		28b. Time of		8c. Injury a	4		l. Describe				y) nos	pice
<u></u>	ath. r: Afe	ato	1 A Natural 2 ☐ Accident	5 Pending investigation		ay rear)	Injury	м		? es 2∐No							
<u>S</u>		Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	289. Place of it	njury - At ho	ome, farm, str	eet, factory	, office		281	Location (er or Rura	al Route Nu	mber,
		Cer												•			
	Hosp 4 hou Fune ely fil	cal	Check only 2	Certifying Ph Medical Exar	ysician: To the bes miner: On the basis	t of my kno-	wledge, deatl	n occurred a	at the time	e, date and p	place, and	due to the	cause(s) and ma	nner as s	tated.	n(s)
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	one) 29b. Signature and titl	1	and manner s	stated.			License							Day, Year)	
}	FXF8		LUD. Giginature and titl	12/	\ -	^	nic		03563								
7	30X1		30. Name and address	11V	completed serves -4	dogth /!to	230\77:==		2000				Jan	uary	9,	2006	
	30		Joseph Ka				aster]		Road.	Rock	villa	e. Ma	rv1s	nd	2085	5	
	Sta	ite	31. Date filed (Month,	<u> </u>		trar's Signa				, 1.001		_ ,	_ ,				
	Regist	rar	JA1	1 0 20	06	a A	y for	ant .									
DH	MH 17 Rev 1/2	001			S. C. C.		15										

				lend item State of Ma	2 per ryland					ind M	-10-06 lental Hy	giene	nns.	003	1. 1.
			State Registrar			Cei	rtificate	e of L	eath			Reg. No:	000	000	ny ny
°.	Physicia	an .	1. Decedent's Name (First, Middle, Last)	ws			A NIDL E	n			2. Date of Dea	Day	2006 ear	3. Time of	n M
	/Medic		JEANNE 4a. Facility Name (If not institution, give si	M.			ANDLE		Location o	of Death	JANUARY		2005 County of Dea	5:00	Α
	Examin	er	803 HOPEWOOD ROAD				.5. 5,		BALT		F			IMORE	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last	birthday)	If Under Months	1 Year Days	If Under :			h V Year)		rthplace (State or country)	r Foreign
	Director		212-01-2402	M 2XF	78	Yrs.	Wioritis	Days	110013		8. Date of Birt (Month, Da APR. 8	, 192	27	MD MD)
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside Cit	v Limits
	Mary	jo	MD BALTI	MORE					RAI T	ГІМОН	RF			1 🗆 Yes	2 No
	r 28a	Director	10e. Street and Number	IOILE			10f. Zip	Code	D, 112	. 11.01		10g. Citiz	en of What C	country?	
	death with the Maryland me 23a or 28a-f ehow		803 HOPEWOOD ROAL)					2120	80				USA	
	r dea	Funeral		Was Decedent Ended Forces?		13.	Was Deced	lent of His	spanic Orig	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)	- 1	4. Race - Am Black, Wh	encan Indian, ite, etc.	
0030	n 72 hours after death with the Marylar "naturel", or fleme 23a or 28e-1 ehow salcal Examinar must be natified at	by Fi	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	0		1□Yes	No K	Specify:			5	Specify:	WHITE	•
3	2 hou		15. Decedent's Educ	ation	1	6a. Dece	dent's Usua	il Occupa	tion			16b. Kin	d of Busines		
2	within 72 ene. than "nai	plei	(Specify only highest grade Elementary/Secondary (0-12)	completed) Coltege (1-4or 5+	-)	(Give	kind of wor DO NOT us	k done d e retired)	uring most	t of worki	ng			·	
7	ed wit	Completed	12 -8-			B00K	KEEPE	R				MED	DICAL		
and	be fill had oth	Be	17. Father's Name (First, Middle, Last)			MITI	- D	1			(First, Middle,	Maiden S		DNOTEIN	
5	hould d Mer marke	ဥ	MORRIS 19a. Informant's Name/Relationship (Type	na Print)		MILL 19b Mailir		(Street a	SAF		ul Route Numbe	ar City or		ERNSTEIN	
<u>∞</u>	od 2 shou ith and M 27 is mar r treumati		DANIEL M. SANDLEI				-				ALTIMOR	-			
<u>5</u>	s 1 and if Heeli item 2 other	1	20a. Method of Disposition		20b. Place	e of Dispo	osition (Nan	ne of	1		ate			r Town, State	
Ē	Page ment o ant: if ury or		1 🕅 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1					01/06	5/2006	WC	ODLAW	N, MD	
Baltimor	permit. Pa Departmen Important: eny injury		21. Signature of Funeral Service License	attle		22	2. Name an	d Addres	s of Facilit	y SOL	LEVINS	SON &	BROS.	, INC. MD 2120	10
A SECTION AND A	4 1/		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused to	the death. [V16669	Approximate Interval Bety	9
	Physician		Immediate Cause (Final disease or condition		rey ort									Onset and D	
	/Medical Examiner		resulting in death)	Due to (or as a										- 0 - 3	·
	LAdrille	L	Sequentially list conditions, b.	The Notice and	#1##1W/#	- n									
	ted nsit	nIne	Sequentially list conditions, I any, leaving to inmediate cause. Enter Underlying Cause (Disease or injury	Lina to (or es a	reunaduen	McHody:									
<u>,</u>	be executed icien and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequen	ce of):									
09/		cal	d.												
ĝ	ng ph	Med	IF FEMALE:							-					
X Q Q	The law requires that the death certificate be executed to has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	☐ Fetal de	ath 3[□Ectopic pr					23	3d. Date of de	,	ear/
- -	the a	yslc	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death	n 5[Other (sp	ecify)						,	
J.	that the de led by the a detached	/ Ph	Part II. Other significant conditions con	tributing to death bu	t not resultin	ng in the u	nderlying ca	ause give	n in Part I.		23e. Did to	obacco us	e contribute	to the cause of d	eath?
dS	w requires t been signe should be		Chresic of	structure pula	no very	1-805					125	Yes 2□]No 3□F	robably 4 🗆	Jnknown
Hecords,	s bee	Completed			-						24a. Was			autopsy findings a	
	hysicien: The law his certificate has b I director, page 2 s	l Wo:										rmed? 205 No	death?	completion of cases 2160 No	ause of
VITAI	sentifica ctor. p	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o				
5	Physicien: r this certific ral director,	၉	1 ☐ Yes 🌠 No	ospital: 1 🗆 Inpatien		/Outpatier			4 🗆 140		me 5 Resid			ecify)	
	ling After fune	lon	27. Manner of Death 1 ♣Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28	b. Time o Injury	и 2 М	8c. Injury Work	at ? ∕es 2 🔲 I		28d. Describe h	now injury	occurred		
DIVISION	l or Attending after death. Director: After in by the fune	flcat	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injur	rv - At home	, farm, st			63 2 🗆		28f. Location /	Street and	Number or F	Rural Route Num	ber.
2	el or / s after il Dire	Certification:	4 Homicide determined	building, etc.	(Specify)			, 511155			City or Tov	vn, State)			,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of et: On the basis of and manner stat	examination	dge, deat and/or in	h occurred ivestigation,	at the tim in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	and manner a place, and du	is stated. ie to the cause(s)
	To the within To the compl	Me	29b. Signature and Hille of certifier				290	. License				29d. Date	signed (Mor	nth, Day, Year)	
}			> Libert C?	5.47				7	20 601	4		1/4	5/06		
	01		30. Name and address of person who con	mpleted cause of de	ath (Item 23	Ba) (Type,	Print)								
40	1		#450; 10755 1	relis to Lu	۱۱ دور ۱۰ از	, Ma	21053		0.				W805, WALLS	1000 March 1967	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 0 201	32. registra	s signature	A	cite								
DH	MH 17 Rev 1/2		07111 - 0 201	JU JULIANO		17				0.165			PRINCIPAL CONTRACTOR		



			1 - For State of Mar	-	ertificate of			giene () () (6 00345
	Physici	an	1. Decedent's Name (First, Middle, Last)				Date of Dea Month	Day Y	3. Time of Death
7	/Medic		HARRIET ELIZABETH	THOMPSO			JANUAR		06 08:11 A
2	Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	4 L	4c. County of	Death / A
S.		W. Committee	JIMA HOSPHOLOF BOILTO		If Under 1 Year	Thora	wy		
1 to 100	Funeral		5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday, 62 Yrs.	Months Days	Hours Min.	8. Date of Birtl (Mortel, Da)	Year)	Birthplace (State or Foreign Country)
9	Director		Usuel Residence of Decedent	02			04/02	/1943	MARYLAND
<i>T</i>	land wo		10a. State 10b. County 1	10c. City, Town or L					10d. Inside City Limits
(,)	the Marylar 28a-f show	ţo	MD N/A	BALT	'IMORE CI	ITY			Yes 2 No
	the note	rec O	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	at Country?
\$	23a or	ā	2653 OSWEGO AVENUE			21215		USA	
Happeier	5-0036 72 hours after death with the Maryland natural; or items 23a or 28a-f show aleas Exactly ser in ust be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ev Armed Forces?	rer in U.S. 13.	. Was Decedent of H If Yes, specify Cuba	dispanic Origin? (Sp	ecify Yes or No-	14. Race -	American Indian, White, etc.
3	after dea	3	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 ☐ No If Yes, Give	,	1 ☐ Yes 2 No		ritouri, oto.)		BLACK
王	5-0036 72 hours atl	d by	3 Widowed 4 Divorced Year or Dates:					эреспу.	
	72 hours	ete	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Giv	edent's Usual Occup re kind of work done DO NOT use retired	pation during most of work	ing	16b. Kind of Busin	ness/Industry
· ·	within she.	E G	Elementary/Secondary (0-12) College (1-4or 5+) 9 T H		USEWIFE	a)		DOMES	TIC
SS	CA B D F F	ပိ	17. Father's Name (First, Middle, Last)			18 Mother's Nam	e (First Middle	Maiden Sumame)	
7	ylanc	To Be Completed	unknown				AE SNE		
3	Maryland 2 Maryland 2 d 2 should be filed the and Mental Hygi to is marked other traumatic svent, 1	۲	19a Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street	and Number or Rur	al Route Numbe	r. City or Town. Sta	ate. Zip Code)
Known			19a. Informant's Name/Relationship (Type, Print) TAVEN T. GORDON / GRAND	265	-				MD 21215
7	re, N		20a. Method of Disposition	20b. Place of Disp		į.	Date	20c. Location - Ci	
	Pages lent of nt: if it		1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	METRO	CREMATO	ŘY ¦01/1	1/06	CATONSV	ILLE, MD
7	프 교육원급 .		21. Signatura of Funeral Service Licensee	7 1	22. Name and Addre	ess of Facility HC	WELL F	UNERAL	HOME 21207
1-	Depa Impo		1/ Whene X. Xx	204/4	1600 LIB				LTIMORE, MD
	X = 1		23a. Patyl. Enter the disease, or complications that caused the shock, or reart failure. List only one cause on each line	he death. Do not er	nter the mode of dyir				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition ACU+	e M.	10 Ca v	dial	Infa	raction	Onset and Death
	/Medical		resulting in death)	consequence of):	1-000				
	Examiner		Sequentially list con thors b.						
	pg ji	Examiner	Sociality list can flunt frame, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	consequence of):					
4	and	Kam	that initiated events resulting in death) Last Due to (or as a	consequence of):					
	60, be ex		5 5 5 6 6 7 25 2	consequence on.					
	Box 68760 eath certificate be eath certificate be eath certificate be eatherding physician for use as the burit	dicai	d						
	oertifi certifi ding	₩	IF FEMALE: 23c. If yes, outcome of	f pregnancy				23d. Date	of delivery
	Bo eath atten for u	cian	in the past 12 months?	Fetal death 3	Ectopic pregnance	у		Month	•
	P.O.	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown						
	that ned by deta	by Physician/Med	Part II. Dther significant conditions contributing to death but	not resulting in the	underlying cause giv	ven in Part I.	23e. Did te	obacco use contrib	ute to the cause of death?
	rds on sign		Obesity				10	res 2.☐No 3	☐ Probably 4 ☐Unknown
	S bee	Completed					24a. Was	an 24b. We	ere autopsy findings available
	Re la le ha age 3	E					autop perfo	rmed? dea	ath?
	tal	0	25. Was case referred to medical			26. Place of Dea			1103 20100
	ysicii ysicii s cer	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatien	nt 2 R/Outpati	ient 3 DOA Ott	har		dence 6 Other	(Specify)
	g Ph ter th		27. Manner of Death 28a. Date of Injury (Month, Day	Year) 28b. Time		ry at	28d. Describe I	now injury occurred	1
	sior andir sath. or: Af	atic	2 Accident investigation	, ,,,,,		Yes 2□No			
	Division of Vital Records, i or Attanding Physicien: The law requires that the death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	ry - At home, farm, s (Specify)	street, factory, office		28f. Location (: City or Tox	Street and Number vn, State)	or Rural Route Number,
	Dital curs at prei Differing								
	Hosg 24 ho Fune Italy f	Medical	29a. Certifier 1 Certifying Physicien: To the best of (Check only one) 2 Medical Exeminer: On the basis of equation of the property of the pro	examination and/or	ath occurred at the ti investigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit	Mec	one) and manner state 29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed ((Month, Day, Year)
	⊬₹≓ŏ		Sm/110 20	0		5493	1		3, 2006
	3		30. Name and ress of person who completed cluse of de-	ath (Item 23a) (Tvn					
	2		SYLVANUS 04090	A, MD	SINAL	HOSPIT	TAL C	F BA	NTIMORS
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar						•
	Regist	trar	JAN 1 0 2006	2 6 B	and the state of				

Robin Therres Unpend item#23a,27, pende 133,3800 II 06-0011 State of Maryland / Department of Health and Mental Hygiene AKG Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Month Year **Physician** January 4, Robin Therres 3:58 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 116 North Paca Street #204 Baltimore n/a If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 218-74-9284 48 Yrs. Director APR 6. <u>Maryland</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? ŏ or Items 23a 116 North Paca Street 21201 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Completed by Specify Specify White 3 ☐ Widowed 4 ☑ Divorced "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed v
Depertment of Heelih and Mental Hygies
Important: if item 27 is marked other th
eny injury or other traumatic event, the Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Milton Mohler Mary Patricia Plein 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary P. Mohler/Mother 7144 Elk Mar Drive Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory, Inc. 1/6/06 21. Signature of Euroral Service Licensee

Flower A. Gregorchik 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia and urosepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit signed by tha ettending physicien and d be deteched for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel dea
4 ☐ Pregnant all time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetel death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ cate has been signe, page 2 should be 4 Unknown 1 ☐ Yes 2 ☐ No Completed 3 Probably autopsy performed? this certificate 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence (Specify) at Scene XXYes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No М within 24 hours efter death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) å 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 5, 2006 30. Name and address of person who completed cause of death (Jun 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland THE ODON MIKE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

				For State Registrar		State	of Ma	ryland		artment <i>tificate</i>				lental Hy	giene Reg. No.	UUD	00347
		Physici	an	1. Decedent's Nam	e (First, Middl	e, Last)								2. Date of Dea	Day	y Year	3. Time of Death
		/Medic	al		is M. T					4b. City.	T	. (January		2006	2:20 PM M
		Examin	er	4a. Facility Name (n, give street and	numb a r)			Cocke					4C.	County of Dea	
		Funeral		5. Social Security N		6. Sex		(In yrs. las	t birthday)	If Under	1 Year	If Unde	r 24 Hrs.	8. Date of Birt (Month, Da	h Varan		thplace (State or Foreign
		Director		238-60-5	5819	1 □ M 2 🔀 F		88	Yrs.	Months	Days	Hours	Min.	June 2			ountry) nnesota
		pue *		Usual Residence o	f Decedent 10b. County			10c. City, 1	Town or Lo	cation							10d. Inside City Limits
		Maryla f sho	ō	MD		imore				svill	۵						1 ☐ Yes 2√2 No
		ith the Marylar or 28a-f show	Director	10e. Street and Nu					- Chej	10f. Zip					10g. Cit	izen of What C	21
		ath with the Maryla 23a or 28a-f shov	ai D	13801	York R	oad A-8						21	030			USA	
		or Itams	ner	11. Marital Status		Armed	Forces?	ver in U.S.	13. \	Was Deced f Yes, spec	ent of Hi	ispanic C an, Mexic	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whi	
2	36	rs afte	by Funerai	1 Never Man		11 1 95,	s 2 ⊠ No Give or Dates:	0		1□Yes 2	2 ∑ No	Specif	y:			Specify: T	white
5	9	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itams 23a or 28a-f show event. I're Madical Exerting relative incitied at	ted t		15. Deceder	t's Education			16a. Deced	dent's Usua	I Occupa	ation			16b. K	ind of Business	l/Industry
5	215	within 7 iene. than "n	Completed	(Spe Elementary/Sec		st grade complete Colleg	e (1-4or 5+	+)	life.	kind of wor DO NOT us	k done d e retired	during mo d)	ost of work	ing			
3	21	e filed wi Il Hygien other th		12	<i>(</i> 5 . 15 . 1		5+			soc	ial	worl		<i>(5)</i>		ourt sy	ystem
3:20 pm	Maryland 21215-0036		Be	17. Father's Name Stanley										e <i>(First, Middl</i> e, ileen H			
12	Z	2 should be fi and Mental H is marked of raumatic ever	2	19a. Informant's N					19b. Mailir	ng Address	(Street a			al Route Numbe			Zip Code)
0		s 1 and 2 should f Health and Mer Itam 27 is marke othar traumatic	1	Lloyd T	yler/s	oouse			1380	1 Yor	k Ro	oad A	A−8 C	ockeysv	ille	, MD 2	21030
3/06	altimore,	es 1 and 2 of Health f Itam 27 i		20a. Method of Dis		3 □Removal fro	om Stata	20b. Plac	e of Disponetery, crer	sition (Nam	ne of ther plac	(e)		Date	20c. Lo	ocation - City or	Town, State
5	<u>E</u>	Pages ment of l ant: If Its lury or o		` 4 🛚 Donation	5-Other (S	ipecify)	_										
=	Ball	permit. Pages. Department of I Important: If Ite any injury or of once.		21. Signature of E	ineral rvice	Licensee S Wade	ire	ctor		Namean State Baltin					. Ва	altimor	e Street
			ľ	23a. Part1. Enter	the disease, o art failure. Lis	complications the	at caused in	the death.	Do not ent	er the mode	e of dyin	ng, such a	is cardiac	or respiratory a	rrest,	20 211 21	Approximate Interval Between
		Physician		tmmediate Cause disease or conditi resulting in death)	on	a	P	NE	UM	MO	A						Onset and Death
		/Medical Examiner		resulting in death,		Due	to (or as a	conseque	nce of):								7.00
			er	Sequentially list c if any, leading to i Cause (Disease o	onditions, mmediate	b. — Due	to (or as a	conseque	nce of):								
		outed id ansit	Examiner	that initiated even	(S	S .											
4	o,	rate be executed obly sician and the burial-transit	Exe	resulting in death)	Last	Due	to (or as a	conseque	nce of):								
10	8760	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dicai			d				_							
13	9 хо	eath certific attending p for use as	/Mec	IF FEMALE:		23c. If yes,	outcome o	of pregnand	*V							004 Data at da	
	Bo	atten atten I for u	Physician/Me	23b. Was decede in the past 13	2 months?	1□Liv	e birth 2	2 Fetal d	eath 3[Ectopic pro		′				23d. Date of de Month	Day Year
5	o.	t the di by the lached	hysi	1 ☐ Yes 2 9 ☐ Unknow		9□ Ur	nknown							S. 72			
	S,	res tha igned l be det	by P	Part II. Other sign	ificant conditi	ons contributing t	o death bu	it not resulti	ing in the u	nderlying ca	ause giv	en in Par	t f.	23e. Did t	obacco t	. /	to the cause of death?
Phyllis	ecords,	w require been si should b		-AT	RIML	- F/C	SKIL	-17	101					10	Yes 2	½ No 3 □ P	robably 4 Unknown
=	ec	e faw r has be	Completed	Cor	1GES	TIVE	HE	AR T		171	-0	KE		24a. Was autor	osv .	24b. Were a	utopsy findings available completion of cause of
3	a R			VA	SOUL	AR I	DEM	IEN	TIA	-				1 ☐ Yes	rmed? 2 No	death? 1 ☐ Ye	s 2 No
<u></u>	Vital	siciar certif irecto	o Be	25. Was case refe examiner? 1 ☐ Yes 2 ■	No medica	Hospital:	☐ Inpatier	- 2DE	2/Outpatier		Cth	05		th (Check only o		0 Flore / C-	
	10	g Phy er this eral d	 -	27. Manney of Dea	ath	28a. Da	ate of Injury Month, Day	y 2	8b. Time o		8c. Injur Wor		wursing Ho	ome 5 Resi			ecity)
	ion	ath. or: Aft	atio	1 Natural 2 Accident		igation	nonin, Day	rear)	Injury	М		Yes 2[□No				
	Division	r Atterde	ertification;	3 Suicide 4 Homicide	6 □ Could deter	nined 288. Pl	lace of Inju uilding, etc	ry - At hom : (Specify)	e, farm, sti	eet, factory	, office			28f. Location (City or To			Rural Route Number,
	۵	pital cours af	O	00- 0-4		- Obverigion T											
		24 hos 24 hos e Funi	edical	29a. Certifier (Check only one)	2 Medica	ng Physician: To Examiner: On th and n	the best of ne basis of nanner sta	examinatio	eage, aeat n and/or in	n occurred vestigation,	at the tin , in my o	me, date i pinion, d	and place, eath occur	red at the time,	date and) and manner a d place, and du	e to the cause(s)
_		To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Diractor: After this certifica completely filled in by the funeral director.	Me	29b. Signature an	d title of certific	ər			110	290	. Licens	e numbe	r		29d. Da	ite signed (Mon	th, Day, Year)
				Bu	rva	ra C	de	500	Ch	2	J	03	383	92		1/3/	2006
				30. Name and add	dress of person	who completed of	ause of de	eath (Item 2	(Type,	Print)	221	1,	nn1.	77	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0-1/:	210,30
			240	31. Date filed (Mo	onth, Day, Year	UKKU	2. Begistra	r's Signatu	U.	1380	7/	yı	UKK	KD.	, U	ickty	SVIUCHE
		St Regist	ate rar		JAN 1	0 2006	A color	e d	1 6	mile				,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item/10 nerfit 051 1:10:06 TT

Department of Health and Mental Hygiene () () () 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 30 AM 2006 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death 1ARFOR Year if Under 24 Hrs. Date of Birth
(Month, Day, Year)

9. Birthplace (State or Foreign
Country)

7 - 21 - 1955

FEMOLULIANA Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) Days Min. 10 M 20 F Months Hours 5-28 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Forest Hill 1 Yes 2 No T 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BIN 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 14. Race 1 Never Married 27 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Alife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) - NOINE ER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RANCEJCO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21656 19a. Informant's Name/Relationship (Type, Print) SHIRLEL · WILE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility EVA 21. Signature of Funeral Service Licensee SO FUNCEAL CHAPEL - BEL AIR TORESI HILL Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myllodysplastic Syndrom disease or condition resulting in death) Due to as a con equence of): The Design of the second of th Disease Sequentially list conditions, Tarry, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Scheme Cordo Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 1 ☐ Yes 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl on examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home Symposidence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \)

Pnysician /Medical Examiner The law requires that the death certificate be executed nding physician a use as the burial-P.O. Box 68760, for ed by the a detached f signed b Division of Vital Records, page 2 should certificate the Hospital or Attending Physician: funeral director, this After death. Director: /

Examine Be Completed by Physician/Medical Certification: To filled in by

Physician

/Medical

Examiner

Funeral

Director

perrit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "naturar, or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examinat must be notified at since.

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be

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24 hours a To the within 2 Manner of Death Natural 2 Accident

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Lephen J. I maldens 29c. License number

29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen O, Imaldore so 31. Date filed (Month, Day, Year) State 1 0 2006 Registrar

29a. Certifier

(Check only one)

Medical

20216 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician January 5:15 PM 2000 SAMUEL TAYLOR /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospita Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 XM 2□ F Yrs. Director WEST VIRGINIA 232-26-7491 83 JUNE 6 1922 Usual Residence of Decedent the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "nature!", or items 23a or 28a-1 show other traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Director BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 919 PAYSON STREET 21217 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 Ayes 2 □ No If Yes, Give Year or Dates: 42/45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Item ony Injury or other traumatic event, the Medical Exercises ones. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: by Specify: BLACK 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION unknown MASONARY/CUSTODIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BEVERLY K TAYLOR MARY ANN DOUGLAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Solomon Taylor/Brother 317 GRANTLEY ST., BALTIMORE, MARYLAND 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 01-17-06 OWINGS MILLS, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 21. Signature of Funeral Bervice Licenses 1206 W NORTH AVENUE ligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Part1. Enter the disease, or comp shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 25 No 2 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number Basel 19515 January, 7, 2006 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALEBRAHIM , 900 Caton Ave. Baltimore, MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 1 0 2006

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Josephine Thornton 1:00 A M nelma 01 03 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL BALTIMORE SAMARITAN G000 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 💢 F Months Days Min. 218.22.2508 76 Yrs. MD Director 06.10. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examinat martic activitied of MD Baltimore 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Street Apt. 309 21218 1040 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1,4or 5+) Elementary/Secondary (0-12) Private Domestic 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi and Mental F is marked of Mildred Coleman Lorenzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) esha Wilkerson Baltimore MD 21239 Grand Daughter Item 27 1336 Pentwood Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ₹ 1 Burial 2 Cremation 3 Removal from State King Memorial Park DILOTIOG Windsor Mill, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vallahn C. Greene Functal Services 4903 York Road Baltmore MD 2 21. Signature of Funeral Service Licensee any tr MD1363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician STAPHYLO COCCAL /Medical Due to (or as a consequence of): Examiner CELLULITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ Pa END RENAL 1 Yes 2 No 3 Probably 4 Uleknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ORONARY 2 No MELLITUS 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ EF/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No his 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural
2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESOOD 01/03/2006 long

Registrar

State

helma

Loch

5601

32 Registrar's Signature

Raven Boulevard Baltimore MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

RAJU

SHUBHA

			For State Registrar	State of Marylar		artment of			giene 006	00351
	Physici /Medic Examin	an al	1. Decedent's Name (First, Middle, Last)		son	4b. City, Town	or Location of C	2. Date of De Month	Day Year	3. Time of Death 7, 50 A M
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Funeral Director		BALL MORE READILI 5. Social Security Number 6. Sex 153 · 16 · 3168	HATION Extension 17. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Day			IV. Year) (C	thplace (State or Foreign ountry) BAMA
	e Maryland ia-f show	ctor	10a. State 10b. County MD NA		ty, Town or Lo					10d. Inside City Limits 1 ✓ Yes 2 No
	23a or 28	Funeral Director	10e. Street and Number 2003 MADISON AVE	NUE		10f. Zip Code			10g. Citizen of What C	ountry?
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. : if Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Ita Medical Examinat must be multified at	Ď	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 12. Was Decedent Ever in U Armed Forces? 1 ØYes 2 ☐ No If Yes, Give Year or Dates: 	1	Nas Decedent of fYes, specify Cu 1 ☐ Yes 2 🔼 N	ıban, Mexican, F	i? (Specify Yes or No Puerto Rican, etc.)	Black, Whi	
21215-0036	e filed within 72 h al Hygiene. I other then "natu vent, Ire Medice	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 1H GRADE		(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of	f working	16b. Kind of Business COPPIN STA	·
yland	should be file and Mental Hy s marked othe umatic event,	To Be (17. Father's Name (First, Middle, Last) JAMES H. WILSON				EXELIN	Name (First, Middle	K	
Baltimore, Maryland	1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relationship (Ty)	(son)	H21	ORDAN sition (Name of			er, City or Town, State, MD 21217 20c. Location - City o	
timor	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 Ceremation 3 R 4 Donation 5 Other (Specify)	emoval from State	cemetery, crer EEUMOU	natory or other p	ol-	11.06	BALTIMORE .	
Bal	Depa impo impo any it		21. Signifure of Funeral Service License 7 aucho 23a. Part1. Enter the disease, or compli		51!	51 BALTO.1	YATE PIKE	1	p 21229	Approximate
8760,	Physician /Medical Examiner Physician and	Ilcal Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	te C	Dis	RASI			Interval Between Onset and Death
P.O. Box 6	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of (aldeath 3 [Ectopic pregnar Other (specify)			23d. Date of de Month	Blivery Day Year
	sign d be	þ	Part II. Other significant conditions cor	atributing to death but not re-	sulting in the u	nderlying cause	given in Part I.		obacco use contribute i Yes 2 🗆 No 3 🗆 F	to the cause of death?
Vital Records,	The ete h	e Completed	25. Was case referred to medical					1 ☐ Yes	psy prior to death? 2 □ No 1 □ Ye	
of	ding Phys h. After this funeral dii	ToB	examiner?	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. in	Other: 4 🗆 Nursi	28d. Describe	dence 6 □Other (Sp.	acify)
Division	tel or Attencts attended the strength of the s	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	eet, factory, offic	e	28f. Location (City or To	Street and Number or F wn, State)	lural Route Number,
	To the Mospitel or Attivition 24 hours after de To the Funeral Direct completely filled in by the	fedical	(Check only 2 Medical Examinate)	ner: On the basis of examinand manner stated.	owledge, deat ation and/or in	vestigation, in m	y opinion, death	plant, and due to the occurred at the time,	date and place, and du	e to the cause(s)
	or Toon	Σ	29b. Signature and title of certifier	Wills W			1365		January	11. Day, Year) 7, 2006 Humur, 21218
	12		30. Name and address of person who co	mpleted cause of death (Ite		Print) Loc	ch Rai	ven Boule	vard, Ba	Hugue, 21218
0.00	Sta Regist		MN 1 0 20	ns Z	4	1 .				

DHMH 17 Rev 1/2001

ORIGINAL

			For	State of Ma		nd / Depa	artmer	nt of H	ealth a		ental Hygi		106	003	52
			1 State Registrar 1. Decedent's Name (First, Middle, Last	1		Cei	rtifica	te of E	Death		Re 2. Date of Death	g. No.			
	Physici		Phyllis Talley	Williams							Month	Day 7	Year	3. Time o	A M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City	, Town, or	Location of		anuary		2006 ounty of Death		
1	LAMIIII	C.	Johns Hopkins Bayview		iter		E	Baltimo	re.				NA		
	Funeral		Social Security Number 6. Se	TM 2006		last birthday)	If Unde Months	Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day,	Year)	9. Birth	place (State ontry)	or Foreign
	Director		214 · 38 · 3004 Usual Residence of Decedent	J.W. 2(9) F	64	Yrs.					15.19	41		MD	
	low low		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside C	ity Limits
	a-fet	ģ	MD NA		BAL	TIMORE	-							1 🗹 Yes	2 □ No
	hours after death with the Maryland turel', or Items 23a or 28a-f show al Examiner must be notified at	Director	10e. Street and Number				10f. Zi	p Code			10	og. Citize	on of What Cou	ntry?	
	s 23s	ra	4132 MARX AVEN					2120					USA		
	Item de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ 1		J.S. 13.	Was Dece If Yes, spe	ecify Cubar	spanic Orig n, Mexican,	in? (Spec , Puerto Ri	fy Yes or No- can, etc.)	12	I. Race - Ameri Black, White,		
036	urs at	ρ	3 ☐ Widowed 4 M Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 1 No	Specify:			S	pecify: BLA	CK	
5-0	CV 65 LI	Completed	15. Decedent's Edi (Specify only highest grad			16a. Dece	dent's Usu	ual Occupa	tion turing most	of working	7	16b. Kind	of Business/In		
121	1 within 7 jiene. r than "n	ldm	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT	use retired,)			ilae	PITAL		
d 2	Hygent, the	e Co	12 1H GRADE 17. Father's Name (First, Middle, Last)			MEDIC	74L ^	IKAIU			First, Middle, N				
au	Mental Mental arked o	m	WILLIAM TALLEY						HILDA						
Maryland 21215-0036	d 2 should th and Men 7 ie marke treumatic	-	19a. Informant's Name/Relationship (T	` ' '		19b. Maili	ng Addres					City or	Town, State, Zij	Code)	
	is 1 and 2 of Health item 27 i		CHARLTON WILLIAM	s (SON))			-	E. B			2120	•		
Baltimore,	of H of H if ite		20a. Method of Disposition 1 2 Surial 2 Cremation 3	Removal from State		Place of Dispo cemetery, crei	osition (Na matory or	ame of other place		Da			ation - City or To		
Him			4 □ Donation 5 □ Other (Specify, 21. Sign ture of Funeral Service Licen.		ME	SIERN	0. \$10			1. 13. (AUSTON	IN N	ND
Bal	permit. Departr Import eny inj		2 aughn			VA	Z. Name a NGHN	C. GE	EEUB	FUNE	PAL SER	VICE	222		
	*		23a, Part1, Enter he disease, or comp	lications that caused	the dea						Auto. Murespiratory arre		221	Approxima	te
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	a. Metas		c Pai	06.50	otic	Car	1000				Interval Be Onset and 3 mor	Death
10	/Medical		resulting in death)	a. Due to (or as			nare	me	Lu	ncer				3 mor	11/15
۱	Examiner	_	Sacuentially list conditions.	b											
J	ed isit	Examiner	Sa uentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consec	quence ot):									
^,	arecu	xar	that initiated events resulting in death) Last	c. Due to (or as	a consec	quence of):									_
760,	ate be executed hysicien and he burial-transit	call		d				. =							
68	leeth certificat ettending phy I for use as th		IF FEMALE:			211-200-0-0						-1-			
Вох	eth ce ttendi or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Feta	aldéath 3[pregnancy				23	ld. Date of deliv Month		Year
0.	at the dec by the e	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	t time of o	death 5	Other (s	specify)					Monar	Duy	1001
σ.	that thed by		Part II. Other significant conditions co	ntributing to death b	out not res	sulting in the u	ınderlying	cause give	en in Part I.		23e. Did tob	acco us	e contribute to t	he cause of	death?
rds	quires n sign uld be	ed by									1 □ Ye	s 2 🛭	No 3□Prol	bably 4	Unknown
Records,	The law requires that the deeth certifica ate hes been signed by the ettending pt page 2 should be detached for use as it	Completed									24a. Was ar		24b. Were auto	opsy findings	available
Ä	The lav	E O									autops:	ned2	death?	2 No	Jause of
/ita	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	(1				100			Check only on				
of Vital	Phys this ral dii	J.	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☑Inpatie 28a. Date of Inju		ER/Outpatie		OA One	er: 4 ☐ Nur		e 5 Reside		Other (Speci	fy)	
	Attending Phir death. sctor: After they the by the funeral	tlon	1 □ Natural 5 ☑ Pending 2 □ Accident investigation	(Month, Da	y Year)	Injury	" м	28c. Injury Work	(? Yes 2 □ ħ		od. Describe No	w mjury	occurred		
Division	or Attendi after death. Director: A in by the fu	Ifica	3 Suicide 6 Could not be determined	289. Place of in	jury - At h	nome, larm, st	reet, lacto	ery, office		28			Number or Rur	al Route Nur	nber,
ā	tel or A rs after el Dirse	Certification:	4 Nomicide	building, et	ic. (Speci	ny)					City or Town	, State)			
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the		(Check only 2∐ Medical Exam	sician: To the best iner: On the basis o	of examin	owledge dead ation and/or in	h sorum	d at the tim	ie date and pinion, deat	d place an	d at the time, da	ate and r	nd mannar as a	utitled o the cause(s)
	thin 2 the p the implet	Medical	29b. Signature and title of certifier	and manner st	ated.			9c. License					signed (Month,		
	F¥F8		I fessive of Co	Elzen	W				S-00	20	2.	11-	1106	, , , , , , , , , , , , , , , , , ,	
•	£		30. Name and address of person who	completed cause of o	death (Ite					-		, T	1		
	6		JESSICA COLBURN	MD. JHB	smc	4940		ERN	AVE.	BAL	.TI MORE	, M	D .5155	4	
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Ogileti	rar's Sign	ature	P								,
100	riegist	rui	I JAN I U ZU	UD DO	40 .	1. 1	101/	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 3. Time of Death **Physician** IRENE ADONA WRIGHT **JANUARY** 2006 2:40PM /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner GNESIS-HERITAGE HOME BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F 218-46-6285 61 Director 04/24/1944 NEW YORK Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD HOWARD COLUMBIA Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 9565 LONG LOOK LANE 21045 USA Funerai or Itame 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK þ 3 Widowed XXDivorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry BALTIMORE CITY than Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOLS permit. Pages 1 and 2 should be filed v. Department of Health and Mental Hygier Important: If item 27 Is marked other th. any injury or other traumatic avent, that once. 12TH YEARS EDUCATOR/TEACHER 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden, Sumame) Be ANTONIO ADONA ISABELLA NUTTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADONA I. WIMBERLY/DAUGHTER 9565 LONG LOOK LANE, COLUMBIA, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ARBUTUS MEM. PARK 01/09/06 BALTIMORE CO., MD 4 □ Donation 5 □ Other (Specify 21. Signal of Funeral Service Lio 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, 23a. Part). Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause onleach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RAK /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physicien Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, (21 Yes 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes 2 DI No 25. Was case referred to examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € 16 2 ER/Outpatient 3 DOA this 27. Manner eath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) After 1 Certification: 28b. Time of 28d. Describe how injury occurred 1 _ fatural 5 Pending Injury s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral I 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

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Name and address of person who completed cause of death (Item 23a) (Type, Print) 8403 (+A127 CED + 121670

32. Registrar's Signature

0 2006

31. Date filed (Month, Day, Year)

Registrar

9

			For State Registrar	State of Ma		d / Depa		of H	ealth a		lental Hy		_	003	54
	Diam'r.		1. Decedent's Name (First, Middle, Last								2. Date of Dea	ath Day	Year	3. Time of	
	Physicia /Medic		FRANK WI	LSON							01	0.3			м900
	Examin		4a. Facility Name (If not institution, give GOOD SAMARITAN HO				45. City, T		Location o	of Death		4c. C	ounty of Dea	ith	
	Funeral		Social Security Number		e (In yrs. la	ast birthday)	If Under	Year	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h v. Year)	9. Bi	rthplace (State o	or Foreign
	Director		734-02-7131	M 2□F	61	Yrs.	Mortura	Days	110013		Feb 20,		4		unk
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							10d. Inside C	ity Limits
	Aaryli sho	ō	MD			ltimo									2 No
	28a-	Director	10e. Street and Number				10f. Zip	Code				10a. Citize	n of What C	ountry?	
	3a or		115 E. Melrose A	venue					1212					•	
	d within 72 hours after death with the Maryland jiene. Than "natural; or Itama 23a or 28a-f show the Medical Exan. ner must be notified at	by Funerai	11. Marital Status unk	12. Was Decedent	Ever in U.S	S. 13.	Was Decede			gin? (Sp	ecify Yes or No- Rican, etc.)	. 14		erican Indian,	
٥	after or Ita	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 1 If Yes, Give	√o u	nk			Specify:	i, Pueno	Hican, etc.)	1	Black, Wh		
Ξ	hours after tural', or Ita		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			1□Yes 2	X 140	зр а спу.				pecify:	black	
9500-61212	72 h "natu	Completed	15. Decedent's Edi (Specify only highest grad	ication le completed)		16a. Dece (Give	dent's Usual kind of worl DO NOT use	Occupa done d	ation <i>Juring</i> mos	t of work	_{ng} unk	18b. Kind	of Busines	s/Industry	unk
2	within 72 ene. than "na	m	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT use	e retirea,)						
	Hygie Hygie other I	ပ္ပ	unk unk 17. Father's Name (First, Middle, Last)	nk				unk	18 Mothe	r's Name	(First, Middle,	Maiden S	umame)		unk
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<u></u>	2 should and Men is marka sumatic	ဥ	19a. Informant's Name/Relationship (T	/pe. Print)		19b. Mailie	na Address	(Street a	ind Numbe	r or Run	al Route Numbe	r. City or 1	Town. State.	Zip Code)	
<u> </u>	d T in		Good Samaritan Ho								altimor				
ē,	s 1 and Heali		20a. Method of Disposition	Бртсат	20b. Pl	ace of Dispo	sition (Nam	e of			Date			r Town, State	
Ē	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 1 ☐ Donation 5 ☒ Other (Specify,	Removal from State		ппесету, стег	natory or ou	Ter place	9)						
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ott		21. Signature Funeral Service Licens			. 22	Name and	Addres	e of Escilit	Roar	d 655 W	. Bal	timor	e Stree	t
ñ	Per F G		mondel 1	Be	-		Baltim		-						
L	200		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death							rest,		Approximat	e waan
	Physician [®]		Imm diate Cause (Final disease or condition	POORLY DI		ATT ATT	EN AN	FNO	ARCIN	AMOL	WITH M	ETDOT	DCIS:	Onset and	Death
	/Medical		resulting in death)	Due to (or as				0,00	0, 1,-0-1	0.000			7317	2.W(ONTRO
	Examiner		Sequentially list conditions,	h											
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	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с											
760,	oe exection significant		sesting in death) case	Due to (or as	a consequ	ience ot):									
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	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be deteched for use as the burial-transit	by Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnar	nev									
Box	atten atten for us	lan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3[Ectopic pre					23	d. Date of de Month	,	Year
о. О	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	Lime of de	racii 3 L	_ Ottier (spe	y/		•					
J.	res that the de signed by the a be detached f	P.	Part II. Other significant conditions co	ntributing to death b	ut not resu	ılting in the u	nderlying ca	use give	on in Part I		23e. Did to	bacco use	e contribute	to the cause of o	death?
Sp	uires sigr ld be										1 🗆 1	/es 2□	No 3□F	Probably 4 🗆	Unknown
<u> </u>	w require been sign should b	lete									24a. Was	an	24b. Were a	utopsy findings	available
Re	he lav e has age 2	Completed										med?	prior to death?	completion of o	ause of
Vital Records,		BeC	25. Was case referred to medical						26 Place	of Deat	1 ☐ Yes	2 3 No	1 ∐ Y €	s 2 No	
	yaici s ceri direct	0	examiner?	Hospital:	ent 2 🗆 i	ER/Outpatier	nt 3 DO	A Othe	ar:		me 5 Resid		□Other (Sp	ecify)	
0	g Phye er this ieral di	n: T	27. Manner of Death	28a. Date of Inju	ry	28b. Time o		Sc. Injury Work	at		28d. Describe I			,,	
Division of	ath. r: Aft	atlo	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y 10a1)	Injury	м		Yes 2	No					
N S	or Attending later death. Director: After in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj	ury - At ho	me, farm, st	reet, factory,	office			28f. Location (S City or Tov	Street and	Number or F	Rural Route Nun	nber,
ā	talours aft	Cer			. (0,000.)							, 0.0.0,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the best iner: On the basis o and manner st	f examinat	wledge, deat ion and/or in	h occurred a vestigation,	it the tim	ne, date an pinion, dea	d place, th occur	and due to the ed at the time,	cause(s) a date and p	nd manner a lace, and du	is stated. ie to the cause(s	s)
	ro th	≅	29b. Signature and title of certifier				29c.	License	number			29d. Date	signed (Mor	nth, Day, Year)	
•	, , , ,		Alexin 1	M.D.			B	97	2688	53		01/	03/0	6	
			30. Name and address of person who of		leath (Item	23a) (Type,					Communication			-	21234
			ADRIAN COSMIN	, GOOD	SAMA	HRITAN	HOSP	TAL	-, 5601	Lock	PAVEN	Boul	EVARD	BALTIMO	RE MO
	Sta	ate	31. Date filed (Month, Day, Year)						7						
	Regist	rar	:AN 1 A 200	32. Registr	· K	Gos	de la								
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 5,9,11,12,14-20c,22 per fh 8852,2-1-06 vt.

State of Maryland / Department of Health and Mental Hygiene 1 per meo g852, 2-7-06 vt.

Amend item 1 per meo g852, 2-7-06 vt.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Walter Wright II Walter Wright January 2006 1320 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** 1731 E. Oliver Street If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Numbernals 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2□F unk 216-48-4970 Yrs Director 58 MD Oct 16, 1947 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits worde | in then "natural", or items 23a or 28e-f ehor The Medical Examinar must be notified at Y☐Yes 2☐No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1731 E. Oliver Street 21213 USA deeth 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. white unk within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: black 3 Widowed 4 Divorced 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UIIK al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Surveyor's Assistant Surveying _ + 4 unk event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk and Mental I unk. å Anne E. Evans Walter O. Wright Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) wother 19800 iina Address (Street and Alumber & Rural R 801 umber City of Jown Mile. 21286 f Health a III Pemi Street Baltimore, altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If Its eny Injury or of once. 1 Burial 2 Fremation 3 Removal from State in state R.A. Ferris & Co. Inc 1-10-06 West Chester, PA. 4 □Donation 5 ☑ Other (Specify) 21. Signature of Funeral Service Licensee Rona S. Hade 22. Name and Address of Facility Hicks Home For Funerals, P.A. /Director State Anatomy Baltimore, MD 21201 103 W. Stockton St. FIkton MD of enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 2192 Interval Between Onset and Death 42011 23a. Part). Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Seizure **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any learned to make a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical SS use IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records, Athenselentic Cardinascular 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2. No Division of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Scene Yes 2□ No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Alter 1 Natural 5 Pending is after dec. 1 ☐ Yes 2 ☐ No investigation M 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in within 24 hours a
To the Funerel I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME January, 4, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABILICAH 111 Penn Street Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year)

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Registrar DHMH 17 Rev 1/2001 The same

			State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Phy C851 1/30/06 CC Registrar	Hygiene Reg. No	006	00356
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21215-0036	ine. Ihan "natural" e Modical Ex	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16b. K	(ind of Business/Ir	ndustry
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~ ₽	Health a		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route) BERTHAM, WALTERS (WIFE) 3432 CARRIGE HILL (IN 20a. Method of Disposition (Name of Date)	RCLE AFT	or Town, State, Zi	p Code) (SC(X) MD, 2113
= 8	Department of Important: if it any injury or o		Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROW	16 CR	DWNSVIL	LE MD.
4			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral shock, or heart failure. List only one cause on each line.	E,B	ALTO, MA	
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To the	within To the comple	Med	29b. Signature and title of certifier **Helleuw Safehart III MD 29c. License number D< 34-00	29d. Da	te signed (Modith,	Day, Year)
3+	4		30. Name and address of per symbol completed cause of death (Item 23a) (Type, Print) ICHART III MD 630/ N CHARUS ST	GALT	mol6 h	0 21212
	Sta Regīstr		31. Date filed (Month, Day, Year) 32. Registrar's Signature		,	

 CPM 06-00149 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend Itany 3,2a,27,2a f, pend 1,251 1/2/06 11 State of Maryland / Department of Health and Mental Hygiene Christopher Wiles 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dat 50014 06, Choistopher Scott

4a. Facility Name (If not institution, give street and number) January 2006 08:35 A^M /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 3017 Arizona Avenue Parkville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days 10 M 2□ F Min Hours Yrs. 26 Director 220-92-8528 April 13,1979 Maryland Usual Residence of Decedent 10a. State 10b. County 8how 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Itams 23s or 28s-f showing the Madical Exercites must be notified at 1 Syes 2 □ No Baltimore Directo Yar Kuille MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 21234 ARIZODO Nenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status s filed within 72 hours after d ! Hygiene. other than "natural", or Itan 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Maryland 21215-0036 þ 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COOK riestauran and Mental Hygie other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William MRISTU acroo6 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Avenue fackuite Macyland 21234

Date 20c. Location - City or Town, State Sherry DOD Gance-aunt 3017 Arizona Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 tment of 1 1 🗷 Burial 2 □ Cremation 3 □ Removal from State ŏ permit. Page Depertment of Important: If ony injury or ORCE. Jan 10, 2001 Kusedale, Marylod Gardens of faith 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Chapel of Memories 18800 Harfred Road Parkville, Maryland 21234 0 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Quetiapine intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physicien and for use es the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an iis certificate has director, page 2 Yes of Vital 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Nother (Specify, SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1XXYes 2 No this After the funeral 28a. Date of Injury Fix 28b. Time of Fix 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred unk Certification: Division 1 Natural 5 ☐ Pending √investigation death. epital or Attendii nours efter death. nerel Director: A 1/6/06 8:30 A 1 ☐ Yes 2 X No 2 Accident 6X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number of Ryral Route Number, City or Town, State) 3017 Arizona Avenue Parkville, MD 21234 4 Homicide Found in residence To the Hoepital within 24 hours of To the Funeral completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. Jule MIN wind January 07, 2006

Registrar

State

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 1 0 2006

D. KURGU

32. Resstrar's Signature

MARYAMOS

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

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		For State Registrar		State of Ma	aryland /	•	artment of H	lealth and M Death		liene 0 0	6 00358	
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3.	Physicia /Medic	an al	MCKin ley	Wid	Eman	Month O	Day Year	435AM
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examinating the notified at once.	1	21. Signature of Funeral Service Licens	······································	22. Name and Address of Facility	Funer	al Home	DA.
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68760,	ficate be executed g physicien and as the burial-transit	edicai		J				
Вох	= =		230. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 DEctopic pregnancy		23d. Date of de Month	elivery Day Year
P.O. E		Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)		WOTH	Day (Ba)
	The law requires that the ate has been signed by the bage 2 should be detache	y Ph	Part II. Other significant conditions co			23e. Did to	bacco use contribute	to the cause of death?
ord	w require been sig should b	ted t	CURUNARY A	RTERY DISE	ASE	-	es 2□No 3□F	Probably 4 Monknown
Rec	has has	omple				24a. Was a autop: perfor	sy prior to death?	
ital		Be Cc	25. Was case referred to nedical		26. Place of [1 Yes Death (Check only or		s 2 No
of V	Physician: this certific al director,	၉	examiner? 1 Yes 2 No 27. Manner Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			ence 6 Other (Sp.	ecify)
ion	Attending Physician: r death. ector: After this certification of the funeral director.	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		28d. Describe II	ow injury occurred	
Division of Vital Records,	P Sign	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	Hospital (24 hours a) Funeral C Interpreted interpret	al Ce	29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, d	death occurred at the time, date and pla	ace, and due to the o	ause(s) and manner a	as stated.
	To the Ho within 24 h	ledical	one)	iner: On the basis of examination and/o and manuer stated.				
\	To To	Σ	29b. Signature and tule of certifier	0	29c. License number		29d. Date signed (Mor	_
	2		30. Name and address of person who co	ompleted cause of death (Item 23a) (Ty			SANUARY	9 2006
	2		LEONARD RICHARDSON	5602 BALTIMORE NI	ATTIONAL PILLE #603 B	BALTIMORE	MD 212	28
Zac. or	Sta Regist		31. Date filed (Month, Day Year)	Registrar's Signature	ale			

			For State Registrar	State of Maryla	and / Depa <i>Cer</i>	artment of H tificate of L	ealth and M Death		ene 0 0 6	00360
	Physicia /Medic		1. Decedent's Name (First, Middle, L MARTIN	ast) WILLIAM	WHITE	JR		2. Date of Death January	8°, 2006°	3. Time of Death 11:50P M
	Examin Funeral	_	4a. Facility Name (If not institution, g 4000 North Charl 5. Social Security Number 6.	es Street #120)9 rs. last birthday)	4b. City, Town, or Baltimo Il Under 1 Year Months Days	Location of Death PC If Under 24 Hrs. Hours Min.	8. Date of Birth	4c. County of Deat N/A 9. Birth	h hplace (State or Foreign untry)
imore, Maryla	Director	tor	212-30-5013 Usual Residence of Decedent 10a. State 10b. County Maryland N/A		City, Town or Lo			June 16,	1932 Mai	ryland 10d. Inside City Limits
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 4000 North Charl			10f. Zip Code 212	218	100	g. Citizen of What Co USA	untry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hyglene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f show supprishing to other treumatic event, ir a Micical Exercities: and be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4	12. Was Decedent Ever in Armed Forces? 15 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	5-157	Was Decedent of Hi f Yes, specify Cuba 1 Yes 2	ispanic Origin? (Spe n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
	d within 72 ho giene. ir then "natu	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired ICE Presi	during most of working)	ng 16	Banking	Industry
	should be file and Mental Hyg s marked othe umatic event,	To Be C	17. Father's Name (First, Middle, La Martin William W	,			18. Mother's Name Marian		aiden Sumame) lliamson	
	1 and 2 sho Health and I tem 27 is mu		19a. Informant's Name/Relationship Barbara Muth Gui	dera PR	8702	Valleyfie	eld Road L	uthervil	le Maryla	nd 21093
	Pages 1 tment of H tant: if ite		20a. Method of Disposition 1 Burial 2 XX remation 3 4 Donation 5 Other (Spe	□Removal from State city) G1	reenMoun	t Cemeter	ry 1/10/	06 Ba	oc. Location - City or	Maryland
Ba	Departic Departic Imports eny Inju		2). Ignature of Funeral Service Lic 2). Ignature of Funeral Service Lic 2). Ignature of Funeral Service Lic 2). Ignature of Funeral Service Lic 2). Ignature of Funeral Service Lic 2). Ignature of Funeral Service Lic	Ren Kenake			6500 York	Road Balti	efeld Funera more, Maryla	
I Records, P.O. Box 68760,	Physician / Medical Examiner buysicien and superintensit	dicai Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ily one cause on each line.	Sequence of):	INFANC	_ \			Interval Between Onset and Death
	The law requires that the death certific tie has been signed by the attending p tage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	quires that n signed b uld be deta	þ		STYPE 2				23e. Did toba	icco use contribute to	othe cause of death?
	The law require ate has been sin page 2 should t	ompleted		NEDWES	- wiT4	METAST	4770	24a. Was an autopsy performs	eg? death?	utopsy findings available completion of cause of
	hysicien: this certifica al director, p	tion; To Be C	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending 2 Accident investiga	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea.	2 ER/Outpatier 28b. Time o Injury	Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 28d. Describe how injury occurred				
	el or Atten s after deal l Directori d in by the	Medical Certification:	3 Suicide 6 Could no 4 Homicide determin	t be One Place of Injury	At home, larm, str ecify)	reet, lactory, office	1	281. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of my caminer: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as se and place, and due	s stated. e to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	MY X Carr	nod		e number	290	d. Date signed (Mont	h, Day, Year)
981	30		30. Name and address of person with Francis X (Carmody MD 7505 (Osler Driv		ryland 2120	4		
14	Sta Regist		31. Date filed (Month, Day, Year)	2006 32 Registrar's S	ignature	340				

			For Stata Registrar	State of I	Maryland		artment of I tificate of	Health and N Death		giene () () Reg. No.	6	00361
	iysicia		1. Decedent's Name <i>(First, Middle</i> Donald Edwin	Wetzel					2. Date of Dea Month Januran	Day	Year 106	3. Time of Death 8:24am M
W. C. St.	Medica camine		4a. Facility Name (If not institution,	-		r	4b. City, Town, Towson	or Location of Death		4c. County Balti	of Death	0.2
E.v.	, oral		Greater Baltim 5. Social Security Number		Age (In yrs. las		If Under 1 Year		8. Date of Birth	1		ace (State or Foreign
- Co.	neral ector		213-01-0039	6. Sex 1 M 2 □ F	93	Yrs.	Months Days	Hours Min.	JWTY, 31	3 Year 1913		Msylvania
land	=		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				10	Od. Inside City Limits
the Marylar 28a-1 ehow	tities	cto	Maryland Anne	Arundel	Li	inthic	um Heigh	nts				1 ☐ Yes 2 ☐ No
with th	Dia rig	Funeral Director	10e. Street and Number 716 N. Hammonds	Formy Dd			10f. Zip Code	2		10g. Citizen of W		try?
leath 1	Tunt	era	11. Marital Status	12. Was Decede		13. \	21090		pecify Yes or No-	U. S.	A. - America	an Indian,
0036 0036 hours after death with the Maryland	undrien	Fun	1 Never Married 2 Marri	Armed Force	es?	1	iYes, specify Cub □Yes 25√2 No	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	Rican, etc.)	Specify.	k, White, e	
5-003	cal Ex	ed by	3 XWidowed 4 ☐ Divorced 15. Decedent	Year or Date		16a, Decec	lent's Usual Occu	nation		16b. Kind of Bu	W	hite
(17)	Medi	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4		(Give life. l	kind of work done OO NOT use retire	a during most of world ad)				·
of filed withing It Hygiene.	nt.		12 17. Father's Name (First, Middle, L	ast)		Cont	rol Room	1 Engineer		Gas and		ctric
aryland 212 2 should be filed within and Mental Hygiene.	tic eve	To Be	Lloyd E. Wet						L. Brol		0)	
re, Marylar s 1 and 2 should but Health and Menta	other traumatic event, the Medical Examiner rount be nutfied at		19a. Informant's Name/Relationsh Donna Balls,				-	t and Number or Rui Hammer Rd		-		
re, M	other	1	20a. Method of Disposition		COO	ce of Dispo	sition (Name of natory or other pla		Date	20c. Location -		wn, State
Page and a second	ury or		1 ¹ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			Have	n Memori	al Park 0			urnie	e, MD
Bartimol permit. Pages Depertment of	any Injury or one		21. Signature of Euneral Service L	icensee		- A	Name and Addr Mbrose F 328 Sulp	ess of Facility uneral Ho hur Sprin	me, Inc.	rhutus	MD	_ 21227
8			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cau	sed the death. h line.							Approximate Interval Between Onset and Death
Physi /Med			Immediate Cause (Final disease or condition resulting in death)	a. Re	Spice	the	y Fai	lure				Criser and Death
Exam			Sequentially list conditions	b. C	SOIC	Ahu	5 pm	EUMON	itis			
V≪ ∑	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	nce of):						
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Box 68 Bath certifica	for use es th	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnand		Ectopic pregnanc	ev			e of deliver	•
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	p o	2	Part II. Other significant condition	ns contributing to deal	h but not result	ing in the u	nderlying cause gi	ven in Part I.				e cause of death?
COFC W requ	plnous	Completed							24a. Was a			psy findings available
I Rec	page 2	Com							autop: perfor 1 Yes	med?	leath?	npletion of cause of 2 ☐ No
Vital F vicion: Th	ector,	Be	25. Was case referred to medical examiner?	Hospital:					th (Check only or	7e)		
Of Phys	9	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of (Month,		R/Outpatien 8b. Time of	1 3U DOA		ome 5 Resid)
sion (he fun	atio	1 Natural 5 Pending investig	ation	Day Year)	Injury		ork?]Yes 2□No				
Division of Vital Records, allorated and Physician: The law requires to after death.	d in by	Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 286. Place of	Injury - At hom , etc. (Specify)	ie, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rural	Route Number,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death.	completely filled in by the	edical	29a. Certifier 1 Certifyin (Check only one) 1 Medical i	g Physician: To the be examiner: On the base and manner	is of examinatio	edge, death on and/or in	occurred at the trestigation, in my	ime, date and place, opinion, death occur	, and due to the c rred at the time, c	ause(s) and mai date and place, a	nner as sta and due to	ated. the cause(s)
To the	compl	¥ €	29b. Signature and title of certifier			2/11	29c. Licen	se number		29d. Date signed	(Month D	Day, Year)
			> /VIT RM	71h.Jch	way	541	JU	14128		01/0	17/0	06
	φ		30. Name and address of person with the [].	Show Completed cause	2MD	3a (Type,	35 Ni	Chade	12 + 20	O Tou	us con	11204 MD
R	Stat egistra	_	31. Date filed (Month, Day, Year) JAN 1	0 2006	istrar's Signatu	re	in the					

State of Maryland / Department of Health and Mental Hygiene 06 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2: 05/ M JANUARY 03 2006 Young /Medical Estella 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City HOSPITAL SINAI OF BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2**X**] F 69 Director 10 36 215-40-6261 GA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Mudical Expranar must be notified at 1 ☐ Yes 🗶☐ No Director Owings Mills MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 1 Beth Ct. U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes YNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2√ Married 1 ☐ Yes 2 ☑ No Specify: Specify ρ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade na Housewife Home land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard Evans Lula Mae Myers Mary 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Alex Young Sr.-Husband 1 Beth Ct., Owings Mills, Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any njury or o XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/11/06 Garrison Forest Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility & lade March F/H West wan 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Carline Physician disease or condition resulting in death) Years 0 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien end s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical ettending (IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 pronths?
1 \(\times\) Yes 2 \(\times\) No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the e Ö 9 Unknown 9 Unknown Records, P. been signed to should be detected to the second to the sec contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an hes ormed? 1 Yes Division of Vital funeral director 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending Injury after death. 1 Yes 2 No 2 Accident investigation the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Hospital 1 Certifying Physician: To the best of my Incivided dath occurred at the time date and place, and due to the dasce(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RSOUD JANUARY 3, 2006 cause of death (Item 23a) (Type, Print) 2401 ARORA WEST BELVEDERE AVE, BALTIMORE, MD21215 MANISH 31. Date filed (Month, Day, Year) JAN 1 0 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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5%.		Ž _{ije}	Decedent's Name (First, Middle, Las	it)				2. Date of Dea	ath	3. Time of Deat	h
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	Examir	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Death		4c. County of	Death	
1	le le	jira.	Baltimore Washin		cal Coriter		urnie		Anne	Arundel	
	Funeral		5. Social Security Number 6. So	TVM 2 TF	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)	 Birthplace (State or For Country) 	өign
	Director		216-42-5833 2 Usual Residence of Decedent		84			Aug 11	, 1921	Wales	
/and	Mo to		10a. State 10b. County	1	Oc. City, Town or Loc	ation				10d. Inside City Lin	nits
Xa	r 28a-f ehow	to	MD Anne	Arundel		Pasa	idena			1 ☐ Yes 2 X ☐	No
death with the Maryland	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?	
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		Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	lf .	as Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race Black,	- American Indian, White, etc.	
0036 Dours after	10,1	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2XXNo If Yes, Give Year or Dates:	1	□Yes 2【XNo	Specify:		Specify:	T71-2+-	
Maryland 21215-0036			15. Decedent's Ed	lucation		ent's Usual Occup			16b. Kind of Busi	White	
1215 With 7	Med	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	lite. C	aind of work done of NOT use retired	during most of working)	ng		,	
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ב ב	tal Hygid d other event, I	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Sumame))	
<u>8</u>	Men	၉	John Henry Yate					abel Ma			
Mar	l and		19a. Informant's Name/Relationship (7				and Number or Rura				
c	f Healt Itsm 27 other t		Mrs. Margaret E. 20a Method of Disposition	Yates / wi	te 8045 20b. Place of Dispos		Hole Roa	d, Pa		Maryland 211 ity or Town, State	122
jo	§ ° = 5		1 Burial 2 Cremation 3 D		cemetery, crem	atory or other place	Jan.	11,			
Baltimore,	artmer ortant Injury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Chesapeak	e Cremat	-			ville, Maryl	
Ball	Departr Importe eny Inju		> male A		M01357		ond Ave SW			1 Home, P.A.	•
27.	* **		23a. Part1. Enter the disease, or comp	olications that caused th	e death. Do not ente					Approximate	
E.	hysician /Medical xaminer		shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	aDue to (or as \$100)	consequence of	faile	ne .			Interval Between Onset and Death	
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a	igned by	y P	Part II. Other significant conditions of	ontributing to death but i	not resulting in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?	?
rds	been sign	D D						1 (1)	es 2□No 3	Probably 4 DUnkno)wn
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Vision	death. ctor: Af y the fur	Certification:	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No				
Divi STA	after d Direct	Ħ.	4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, stre (Specify)	et, factory, office	2	8f. Location (S City or Tow	Street and Number In, State)	or Rural Route Number,	
- Island	ours a		29a, Certifier 1 Centifying Ph	Walishers To the book of		2000 00 2002 2003	A CONTRACTOR OF STATE OF	- 412 STV - 21V -		one of the same of	
	Fun Fun	Medicai	(Check only 2 Medical Exam	ysician: To the best of r niner: On the basis of ex and manner state	ramination and/or inv	estigation, in my o	na, data and place, a pinion, death occurre	nd dua to the o d at the time, o	date and place, an	d due to the cause(s)	
To the	within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed (Month, Day, Year)	
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	1		30. Name and address of person who	completed cause of dear	th (Item 23a) (Type, F	Print)	- 1 F 1 P/		- The state of the	7 2006	
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YATES, William

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 00364 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 12-05A M 2006 ANUARY **Physician** Yogan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Fecility Name (If not institution, give street and number) Examiner ANNE ARINDEL SALTIMOREWASHINGTON MEDICAL CENTRE BURNIE CILPH Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-10-1914 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Hours Months 1200M 2 . F PA 191-01-4818 91 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Anne Arundel Odenton 0 4 1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 1395 Odenton Road 21113 or Itams 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 2Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after Hygiene. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: Certition y þ 3 Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "a eny injury or other treumatic event, In a Madia 2006. College (1-4or 5+) Elementary/Secondary (0-12) Intelligence Officer 3 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Sabljic Matthew Yogan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1395 Odenton Road; Odenton, MD 21113 Mrs. Hazel Yogan / Wife 20c. Location - City or Town, Sfate 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donayor 5 □ Other (Snaniki) 20a. Method of Disposition Ft. Meyer, VA Arlington National Cem. 2-1-2006 22. Name and Address of Facility Singleton Funeral Home, PA Service Licensee 21. Signature 1 Second Ave SW; Glen Burnie, MD 21061 m01120 a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART TAHURE CONGESTIVE **Physician** /Medical Due to (or as a consequence of): Examiner FIBRILATION TRIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit The faw requires that the death certificate be executed OSTATE Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions confributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No 2 No 1 Yes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 No 2 ER/Outpatient 3 DOA 1 hpatient Certification: To 1 Yes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 27. Manner of Death After 1 Natural 5 Pending 1 Tyes 2 No death. investigation 2 Accident completely filled in by the Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the 29d. Dale signed (Month, Dey, Year) 29b. Signature and the of certifier 29c. License number 5 2006 1>45,40 MI ANUAFY LB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elenburne MF) 21061 301. 800 QUICE CNABA stal

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Registrar

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 🕕 🗍 🖯	0036

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State of Maryland / Department of Health and Mental Hygiene.

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	lending Physeath. cor: After this in the funeral direction	ation: To	27. Manner of Death 1 Natural 2 Accident		28a. Date (Mo	Inpatien e of Injury onth, Day	, ;	R/Outpatier 28b. Time o Injury		28c. Injun Wor	v at		me 5 Res 28d. Describe				y)
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	\mathcal{I}_i		30. Name and addre					23a) (Type,	Print)	Ray	gni	Me	ena				
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To set the second property of the second prop	Maryland -f ehow	tor	10a. State 10b. County									
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of drying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	al', or iteme 2 Examinar mul	by	1 Never Married 2 Married	Armed Forces?	No				Specify Yes or N to Rican, etc.)		Black, Whit	te, etc.
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inferval Between Christ and Death of Carnoc Carn	27 is mai r traumai		19a. Informant's Name/Relationship Barbara J Badonieo	(Type, Print) : (Wife)		19b. Mailing Addres 420 Elmwood	s (Street a	and Number or R Baltimo	re,Maryla	nd 212	Jown, State, . 06	Zip Code)
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of drying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	t: If item y or othe		1 Burial 2 Cremation 3		ceme	etery, crematory or	other plac					
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building, etc. (Specify)	Medical caminer prize pr	cal	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, basing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as b. Due to (or as c.	a consequen	ncer ce of):	-001	701)				Interval Between
Part fi. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Holdenown 24a. Was an autopsy performed? prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1		ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1⊡Live birth 4⊡Pregnant <i>a</i>	2 Fetal de	ath 3 Ectopic				2		,
autopsy performed? The performed completion of cause of death? The performed completion of cause of death?	signed b	Ď	Part fl. Other significant conditions	contributing to death b	out not resultin	ng in the underlying	cause giv	en in Part I.	1			,
25. Was case referred to medical examiner? 1	ete has beel page 2 shou	Complete					****		auto perf	opsy ormed?	death?	
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building, etc. (Specify)	his co	2	1 ☐ Yes 2 ②No	1 L Inpatio			- L	4 Ivuising i	T			ecify)
building, etc. (Specify)	eath. or: After t the funera	catlon:	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Da	y Year)	In j ury M	Wor 1 🗆	k?				
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Ugense number 29c. Ugense number 29d. Date signed (Month, Day, Year)	ral Directed in by		d-to-mino	d 286. Place of the	rury - At home ic. (Specify)	e, farm, street, facto	ory, office		City or To	own, State)) 	urai Houte Number,
29c. License number 29d. Date signed (Month, Day, Year)	in 24 hou he Fune pietely fil	edical	(Check only 2 Medical Ex.	miner: On the basis of	f examination					, date and	place, and due	e to the cause(s)
	To	Z	29b. Signature and title of certifier	Solepell	\wedge	2	9c. Licens	e S Ø Ø	\$ \$	29d. Date	3/05	th, Day, Year)

			For State Registrer		State	of Marylar		artment <i>rtificate</i>				lental Hy	/giene Reg. Nic.	06	0036	9
	Physici		1. Decedent's Name									2. Date of D Month	Day	Year 200	3. Time of De.	
	/Medi Examir		4a. Facility Name (If			number)		4b. City, T	own, or	Location	of Death	ouru	Gc. Col	unty of Dea	W-1	
					Nursing		to a total to	+		r1and		0.5		l1ega		
	Funeral Director		5. Social Security No. 232-26-3		6. Sex 1 ∑ M 2☐ F	7. Age (In yrs.		Months	Days	Hours	Min.	8. Date of Bi (Month, D	irth Pay, Year) 28,191	9. BI	irthplace (State or Fo Country) ancock, M	oreign D
	D D		Usual Residence of	Decedent				<u> </u>				imicii	20,171	<u> </u>		
	Maryland I show	'n	10a. State	10b. County		10c. Ci	ty, Town or L								10d. Inside City L 1 ☐ Yes 2	
	ith with the Marylan 23a or 28a-f show ust be notified at	Funeral Director	10e. Street and Num		eral		Ridge	10f. Zip (Code				10g. Citizen	of What C		
	h with	E D	Rt. 3	, Box	426				2675	53			3	USA	ŕ	
$\dot{\omega}$	SE E	ner	11. Marital Status		12. Was Do	ecedent Ever in U Forces?	J.S. 13.	Was Decede			igin? (Spe	ecity Yes or N Rican, etc.)	0- 14. [nerican Indian,	
36		by Fu	1 Never Marrie		If Yes,	s 2 ⊡ No Give r Dates: T.T.J		1 ☐ Yes 2						ecify:		
- h	72 hours after c "netural", or iter edical Examinat	ted t		15. Deceder	nt's Education		II 16a. Dece	dent's Usual	Occupa	ition			16b. Kind o	f Busines	White s/Industry	
	C	Completed	(Speci Elementary/Secor		st grade complete College	ed) e (1-4or 5+)	(Give	kind of work DO NOT use	(done d e retired)	<i>luri</i> n <i>g m</i> os)	it of worki	ng				
√ ½	led wi lygien her th	So	17. Father's Name (Cine Adidala	(1004)		С	lerk_	1	10 11-11-	d. Ni.	/5: A4:1 #		Railr	oad	
>, Rali and 2121	d be fi	To Be		d Bish									e, Maiden Sun	name)		
no Mary	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any njury or other treumatic event, ITE MADDE.	F	19a. Informant's Na		_		19b. Maili	ing Address ((Street a			nia Bu t U Route Numb	cier_ ber, City or To	wn, State,	Zip Code)	
Bisho Baltimore, Mary	and 2 salth s n 27 ls		Anna Brid	lges/	Daughter			13 Pro		Roa	d, N	.W. C	umberla	ınd ,	MD 21502	
Bis	ges 1 t of H ₆ If iter or oth	ľ	20a. Method of Disp 1 X Burial 2		3 □Removal fro		Place of Dispersion of Place o	osition (Name matory or oth	e of her place	9)	Jan	ate 6	20c. Location	on - City o	r Town, State	
E P	it. Par itmen rtant: njury	1	' 4 ☐ Donation 21. Signature of Eur			Que	een's]				2	006	Keys	er, l	WV	
Ba	Deparenti Deparenti Impo any ir		21. Signature of Fig.	A dead	Licensee	511	- / -	2. Name and			S ₁		uneral			
			23a. Part1. Enter th	e disease, o	r complications that only one cause of	at caused the deal	th. Do not en	ter the mode	of dying	n St g, such as	reet cardiac c	r respiratory a	er, WV arrest,	26	726 Approximate Interval Betwee	
	Priysician		Immediate Cause (I	Final		therosc	lerotro	Can	dio	Vasca	elun	dise	250		Onset and Deat	ith
	/Medical Examiner		resulting in death)		- u.	to (or as a consec									2700	4
		Į.	Sequentially list con	ditions,	b	to (or as a consu	mence (f)									
	uted d ansit	Examiner	cause. Enter Under Cause (Disease or i that initiated events	lying - njury	S c.		,									
0,	ate be executed hysician and the burial-transit		resulting in death) L	ast		to (or as a consec	quence of):									
8760,	ate hy the	dical			d											
9 x 6	The law requires that the death certificate be exite has been signed by the attending physician bage 2 should be detached for use as the burian	Completed by Physician/Me	IF FEMALE: 23b. Was decedent		23c. If yes,	outcome of pregna	ancy	W =				-	234	Date of de	eliven	
. Box	death e atter d for u	lciar	in the past 12 r	nonths?	4□Pre	e birth 2 ☐ Feta agnant at time of c		⊒Ectopic pre ⊒ Other (s <i>pe</i>						Month	Day Year	r
P.O.	that the de led by the a detached t	hys	9 🗆 Unknown		9□ Un											
S,	w requires that s been signed b should be deta	by	Part II. Other signifi		ons contributing to	o death but not res		1.5	_	n in Part I	,		tobacco use c Yes 2 □ No		to the cause of death Probably 4 Munkn	
örc	v requ	etec	CVVVC	rnc	UNST FUE	1110 =0	8 - 5	u seals								
Division of Vital Records,	he lav e has age 2:	duic										24a. Was auto perf		prior to death?	tutopsy findings avail completion of cause	e of
ital		a)	25. Was case referr	ed to medica	ı					26. Place	of Death	1 Yes	one)	1 🗆 Ye:	s 2D No	
Ž	Physicien: this certific ral director,	To B	examiner?	No	Hospital:	☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA	Otho	r V			idence 6 🗆	Other (Spe	ecify)	
o u	D 9 90	.i.o	27. Manner of Death	5 Pendir	ng (M	te of Injury onth, Day Year)	28b. Time o Injury		c. Injury Work	?		28d. Describe	how injury occ	curred		
isio	Attending or death. sctor: After by the fune	icat	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	not be	ace of Injury - At h	ome farm st	M reat factory		'es 2□		ORF Location	(Street and Nu	mber or F	Rural Route Number,	
Ωİ	afor A after Direct	Certification:	4 Homicide	detem	nined 200. Fig	ilding, etc. (Special	fy)	reet, ractory,	Unice		4	City or To	wn, State)	moer or n	urai Houte Ivumber,	
	To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: At completely filled in by the fu	Medical C	29a. Certifier (Check only one)	1 Certifyii 2 Medicel	ng Physician: To t Examiner: On the and m	a basis of examina	ation and/or in	vestigation i	n my on	inion dea	th occurre	ad at the time.	date and place	e and du	e to the cause(s)	
	To th To th comp	Me	29b. Signature and I	title of certifie	or			29c.	License	number			29d. Date sig	ned (Mon	th, Day, Year)	
	0		wo	user	keller	i Ms	D	+	‡ D	55	32	5	Jan o	4,21	505	
6)		30. Name and addre	1	who completed ca	anner stated. Ause of death (Iter 48 Registrar's Sign	n 23a) (Type,	Print) Terra	ce	Fros	stbu	ra. h	4D 2	153	2	
	Sta	-	31. Date filed (Monti	h. Dav. Year	2006	. Registrar's Sign	ature A	affect.				5'				
	Regist	ar	JM	1 1 2 1	- Colo	STATE SALE	S. S. S. S. S. S. S. S. S. S. S. S. S. S									

			For State Registrar	State of Ma	•	partment of He ertificate of D			ene 006	00371
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		Ellis T	ruesdale	Bolton			January		6 4:45P M
1	Examin	er	4a. Facility Name (If not institution, give		Q = b =	4b. City, Town, or			4c. County of Dea	
			Fairhaven Heal 5. Social Security Number 6. Se		e (In yrs. last birthda	Sykesv	If Under 24 Hrs.	8. Date of Birth	Carrol	thplace (State or Foreign
	Funeral Director			_M 2□F	83 Yrs.	Months Days	Hours Min.	5-4. Day.	22 C	NJ
	g		Usual Residence of Decedent		10- 0"- "					Land to the second
	anyta shov	'n	10a. State 10b. County	1.1	10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 21 No
	28a-f	ect	MD Carro	<u>T T </u>	Буке	sville		100	g. Citizen of What C	<u> </u>
	3a or	Funeral Director	7200 Third Av	enue			784		USA	.,
	death	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spendar)	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	ba ilied within 72 hours after death with the Maryland Ital Hygiene. Ital Hygiene. Ital Hygiene than "natural", or Itams 23a or 28a-f show event, the Modical Exertinational be rediffed at	by Fu	1 Never Married 2 Married	1X Yes 2 ☐ 1 If Yes, Give	™ WWII	1 ☐ Yes X☐ No	Specify:	, main, oran	Specify: W	
21215-0036	tural'	ed p	3X Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:		cedent's Usual Occupa	tion	16	Sb. Kind of Business	/Industry
215	hin 72	Completed	(Specify only highest grad Elementary/Secondary (0-12)		(Gi	ve kind of work done d b. DO NOT use retired)	uring most of worki	ng		,
	a filed within al Hygiene. I other than '	Com		8		Scientist			Education	on
and	ba fill ntal Hy od oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
Maryland	should be nd Menta s marked umatic ev	유	Elliott L. Bo 19a. Informant's Name/Relationship (T)		19h Ma	illing Address (Street a			oven Li	
Ma	d 2 s th ar 7 is trau		Mr. Roger T. B			02 Gue Ro		·		 3333)
Je,	of Heal of Heal itam 2	13	20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other place			Oc. Location - City or	Town, State
imo	Page ment c		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,			unty Crem		/10/05	Sykesvi	lle, MD
Baltimore,	permit. Pages of Popartment of Popartment: If its any injury or of once.		21. Signature of Funeral Service Licens	Hand A		22 Name and Addres HAIGHT FU Box 195 S	of Facility NERAL H Sykesyil	OME & C	HAPEL, 1	P.A.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each li	the death. Do not	enter the mode of dying	, such as cardiac o	r respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	chis.	11:0	bitert	V+ P	/money	Diserra	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
		er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence of).		- 14.0°			
./	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	a exec an an irial-tr	Еха	resulting in death) Last	Due to (or as	a consequence of):					
28760,<	aath certificate be executed attending physician and for use as the burial-transit	edicai		d						
_	certific Iding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of de	livery
Вох	death a atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at		3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
P.O.	at the de by the tachad	hys	9 Unknown	9□Unknown				_		
of Vital Records, F	as the gned	þ	Part II. Other significant conditions of		ut not resulting in the	underlying cause give	n in Part I.		cco use contribute to	the cause of death?
CO	aw require ts baen si 2 should t	Completed						24a. Was an	24b. Were at	utopsy findings available
Re	The lay ate has page 2	mo						autopsy performe	ed? death?	completion of cause of : 2□ No
ita	sician: 1 certifical irector, p	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
of V	hys this aldii	မ	1 Yes 2 No		nt 2 ER/Outpat		4 Nursing Hor		ce 6 □Other (Spe	cify)
ono	ding h. After fune	tion:	27. Manner of Death A Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injur	y Work	at ? ′es 2 ∐ No	28d. Describe how	injury occurred	
Division	ten feat tor: the	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj	ury - At home, farm,	street, factory, office			et and Number or R	ural Route Number,
ā	F 6 F C	Certification:	4 Homicide determined	building, et	c. (Specify)			City or Town,	State)	
	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	Medicai (examination and/or	eath occurred at the tim investigation, in my op				
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Mont	h, Day, Year)
			Port 2.	Men.	Mo	O'S	2001		1/7/5	> <
	15		30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Typ	Print)	C	(D.	Rest	2113;
	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 1 20	32. Jegistr	ar's Signature	Society)				31131
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			1 _ State	Department of Health and M Certificate of Death	ental Hygien	1000 00017
			1. Decedent's Name (First, Middle, Last)	Continuate of Death	2. Date of Death	3. Time of Death
	Physicia	an	Betty Low Drown		January D	ay Year 440 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
	Examin	er	Process March 10	E she x		Baltimore.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last It	pirthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		214-26-2875 10M 20F 73	Yrs. Months Days Hours Min.	(Month, Day, Year	3.1930 Country) M.D
	p .		Usual Residence of Decedent			
	anylar show	_	4/1	wn or Location		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f	cto	MD Balhmere	Dundalk		
	with th	Dire	10e. Street and Number	10f. Zip Code	10g. C	citizen of What Country?
	s 238	Funeral Director	3138 Day Driak Kd.	2 /222	aifu Vac ar Na	14. Race - American Indian,
	er de Item	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, White, etc.
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Evartiner nast ke nolithed at	by F	If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
21215-0036	2 hou	ted		Sa. Decedent's Usual Occupation	16b.	Kind of Business/Industry
25	hin 7.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	19	\circ
21	e filed within at Hygiene. other than '	no.	10	Manufacturing Worker		Trinking
p	be filed within 72 hours after death with the Marylan hat Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Evantiner must be rediffed at	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	n Sumame)
<u>Ja</u>	should bind Ment marked umatic e	ပို	John Meyer	Lydia	Dertha	Datton
Maryland	2 should be and Mental is marked c		19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Rura	I Route Number, City	or Town, State, Zip Code)
	12 E E		LINDA Kelly - NIEZE	7012 October Rd. of Disposition (Name of D	Divida/	mo 21222
Ore	Pages 1 al nent of Hea int: If item iry or othe		20a. Method of Disposition 20b. Place 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b.	tery, crematory or other place)	/ 200.	Location - City or Town, State
ţ	t. Pa tmen rtant: vjury		'4 □Donation 5 □Other (Specify)	in Crematory 1/7	104 00	Atimore, NID
Baltimore,	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licensee	22. Name and Addr ss of Facility Dradley-As top	FUNCTAL	Home, P.A.
	20200		23a. Part1. Enter the disease, or complications that caused the death. D	o not enter the mode of dving, such as cardiac of	r respiratory arrest	Rol. 2/222 Approximate
			shock, or heart failure. List only one cause on each line.	2		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence)	RUTIC GARBIOVASC	O LARL))/JEANSE
	Examiner		Due to (or as a consequence	.e oi).		
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	e of):		
V	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
ó,	an ar		resulting in death) Last Due to (or as a consequence	ee of):		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d			
9	artifica ing pl	Med	IF FEMALE:			
Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 modbs? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea		ĺ	23d. Date of delivery Month Day Year
0	at the de by the a tached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 Other (specify)		
<u>α</u>	that the		Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Records,	uires sign ld be	d by	DEMENTIA		1 🗆 Yes	2 No 3 Probably 4 Dunknown
cor	w require been sig should b	ete			24a. Was an	24b. Were autopsy findings available
Re	The lav	Completed			autopsy performed?	prior to completion of cause of death?
la		e C	25. Was case referred to medical	26. Place of Death	(Check only one)	lo 1 Yes 2 No
>	ysician: is certific director,	0 8	examiner? 1 ☐ Yes 2 ☐ M6 Hospital: 1 ☐ Inpatient 2 ☐ ER/	Othor		6 ☐ Other (Specify)
J Of	g Phy ler thi	n:	- (Month Cay Voar)		28d. Describe how inj	
ior	andin ath. or: Aft	atio	2 Accident investigation	M 1 Yes 2 No		
Division	r Atter de irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
Ω	urs af					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier 1 Certifying Physician: To the best of my knowled (Check only one) Medical Examiner: On the basis of examination and manner stated.			
	To thi Within To thi compl	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
	, ,, ,		Yah (Clother)	D0060560	JAN	JUARY 6, 2006
	n		30. Name and address of person who completed cause of death (Item 23:	a) (Type, Print)		7
_				ACKRIVER NECK F	D. HER	BALTIMORE, MD
-		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			/
	Regist	rar	JAN 1 1 2006	Louis 1		

		•	For State of Maryl		artment of h			iene g. N2. 006	00373
	4 4 4	4	Registrar 1. Decedent's Name (First, Middle, Last)		ranouto or	D04.77	2. Date of Deat		3. Time of Death
Phy	sicia	in		Blight,	Jr.		January	6, 2006	6:15 A ^M
	ledic	-	Leonard M. 4a. Facility Name (If not institution, give street and number)	bright,		or Location of Death		4c. County of Dea	
Exa	amine	<u>ş</u> r	3209 Orlando Avenue			more City		N//	
5 P	3 N			yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	1	thplace (State or Foreign
Fune Direc	_	- 1	212-32-5868 ^{1⊠M 2□F} 72	Yrs.	Months Days	Hours Min.	July 5,	Year) Co	ryland
		1	Usual Residence of Decedent				oury 5,	1500 110	1 J Lana
yland	=			. City, Town or Lo					10d. Inside City Limits
Mar.	9	ğ	Maryland N/A	Baltimon	re City				1 X Yes 2 ☐ No
h the	0	lre	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
th wil	9	by Funeral Director	3209 Orlando Avenue		212	234		U.S.A.	
dea	ğ	ner	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puert	ecify Yes or No-	14. Race - Ame Black, Whit	
or It	Ē	린	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2 【X No		1 ☐ Yes 2 X No		,,	1	White
ours in all,	4		3 Widowed 4 Divorced Year or Dates:						
72 H	5	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done	during most of work	king	16b. Kind of Business	/Industry
the at	4	du	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retire Minister	na)		Church	
lled v	e E	ပိ	12 4 17. Father's Name (First, Middle, Last)		MIIIIZCEI	18 Mother's Nam	ne (First, Middle, N		
be fi	>	Be		ight		Kather		Marie	Smith
If y Id II Z Z D-UO30 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked othar than "natural", or Itams 23a or 28a-f show	natic	၉	19a. Informant's Name/Relationship (Type, Print)	<u> </u>	na Address (Stran			City or Town, State,	
DENTITIOTE, INICITY INTO A LATE 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If I tem 27 is marked other than "natural", or I tams 23e or 28e-f show	traur		Mrs. Shelva J. Blight - Wife		Orlando			MD 21234	zip code)
Tangart death	ther.	}		Ob. Place of Dispo		7,70		20c. Location - City or	Town State
in a little in a l	0		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crea	matory or other pla				
Daltimor	dury		4 Donation 5 Other (Specify)		od Cemete		2006	Baltimore	
Depariment of the property of	ny ir		21. Signature of Funeral Service Licensee	7	2. Name and Addre	Dd		Maryland 2	
4 402			Ca Part Form the disease of complications that around the			. Ruck, I		Harford	Approximate
			23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line.	Jeath. Do not en	ter the mode of dyl	ng, such as cardiac	or respiratory arre	ost,	Interval Between Onset and Death
Physic			Immediate Cause (Final disease or condition resulting in death)	Guc	ER				2 YEARS
/Medi Exami			Due to (or as a cor	rsequence of):					
			Sequentially list conditions, b.						
p _e	S	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	isequence or):					
ecut	-tran	Examiner	resulting in death) Last C Due to (or as a cor	nsequence of):					
COIGS, P.O. BOX 08/00, w requires that the death certificate be executed been signed by the attending physicien and	buria	calE	500 to (6) 43 4 66.	1504001100 01).					
oo/ou	t e		d						
OX O	Seas	Physician/Med	IF FEMALE: 23c. If yes, outcome of pr	ennancy				024 D-144-	
death death	io io	lan	in the past 12 months?	Fetal death 3	☐Ectopic pregnanc ☐ Other (specify) _	:y		23d. Date of de Month	Day Year
. a a a .	ped:	yslc	1 Yes 2 No 9 Unknown	ordeath 5L	_ Other (specify) _				
ords, F.C. requires that the	detac	4	Part II. Other significant conditions contributing to death but no	t resulting in the u	underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds, urres t	d be	p		•	, , ,		1 ☐ Ye	s 2 10 3 P	robably 4 Unknown
w requ	hou	ete					24. 345	0.45 144	
e law	62	Completed					24a. Was ar autops perforn	24b. Were at prior to death?	utopsy findings available completion of cause of
on of Vital Red ding Physician: The lav h. Atter this certificete has	bad	S					1 ☐ Yes 2		2 □ No
Of VITAL Physician: This certifice	ector	Be	25. Was case referred to medical examiner? Hospital:		0+	has	th (Check only on		
Phys	<u>a</u>	٩	1 Inpatient	2 ER/Outpatier	III OLI DOX	4 [] [4di 3ilig 7]	ome 5 Reside 28d. Describe ho	nce 6 Other (Spe	ecify)
ling Atter	luner	lo	1 ☑ Natural 5 ☐ Pending (Month, Day Yea	ar) Injury	Wo	ryat ork?]Yes 2∐No	28d. Describe no	w injury occurred	
ISIC ISIC ISIC ISIC	the the	cat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury -	At home form st]163 2 160	28f Location (St	eet and Number or R	ural Pouta Number
DIVISION I or Attending atter death. Director: Atte	r b	Certification:	4 Homicide determined building, etc. (S)	pecify)	reet, ractory, office		City or Town		BIAI FIODIO INDINDO,
pital Durs Durs	tilled	Ö	29a. Certifier 1 Certifying Physician: To the best of my	knowledge deal	th occurred at the t	ime, date and place	and due to the ca	use(s) and manner a	s stated
DIVISION OF To the Hospital or Attending PI within 24 hours after death. To the Funeral Director: Attent	etely	edical	(Check only 2 Medical Examiner: On the basis of examiner)	mination and/or in	nvestigation, in my	opinion, death occu	rred at the time, da	ite and place, and du	e to the cause(s)
o th	dwo	₩.	29b. Signature and title of certifier		29c. Licen	se number	25	d. Date signed (Mon	h, Day, Year)
+ s ⊢ }	٥				De	-0000		1-9-06	
209			30. Name and address of person who completed cause of death	(Item 23a) (Type		59858		1-1-00	
30						BALTT	02 -000	YUND 2	1231
PORE TO A	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's S	ignature	-1460VIA7	WHY IND	KE PULLER	COND Z	162/
Re	gístr		JAN 1 1 2006	B. B	cartie			,	

		1	For State Registrar	State of Maryland		artment of Hertificate of C			giene Reg. No.	00374
	Physicia	100	1. Decedent's Name (First, Middle, Last		h			2. Date of Dea Month	Day Year	
· · · · · · · · · · · · · · · · · · ·	/Medic	al -	Palmer Chri 4a. Facility Name (If not institution, give		1	4b. City, Town, or	Location of Death	JANUAR	Y 7, 2006 4c. County of De	
		eı	Saint Joseph M	ledical Cent	er		Towso			cimore
	uneral irector		5. Social Security Number 6. Se 040-24-8192	7. Age (In yrs.) M 2 F 75	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da Sept.	26, 1930 9. 86	inhplace (State or Foreign Country) Connecticut
and	MC 17	⊢	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	ocation				10d. Inside City Limits
Магу	a-f sho	tor	Md. Baltimor	e To	wson					1 ☐ Yes 2 No
h with the	3a or 28	Funeral Director	10e. Street and Number 305 E. Joppa Rd.	#1710		10f. Zip Code 21286			10g. Citizen of What C	Country? USA
aryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mantal Hyciene.	Importances or results and weater bygone. Important: If tem 27 is marked other then "natural; or items 23a or 28a-f show eny injury or other traumatic event, the Madical Exercise must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4X☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☐ No	n, Mexican, Puerto	ecify Yes or No Rican, etc.)	Black, Wh	
5-0	natur	eted	15. Decedent's Edu (Specify only highest grad	ucation le completed)	(Give	dent's Usual Occupa kind of work done do DO NOT use retired)	luring most of work	ring	16b. Kind of Busines	s/Industry
within within	then the Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) +4		nnical Wri			Technical	Writing
land 2	ked other	To Be Co	17. Father's Name (First, Middle, Last) William Bassich				18. Mother's Nam Caroli	e (First, Middle, ne Sac	Maiden Sumame) hotski	
Mary nd 2 shoul	27 Is mari	i i	19a. Informant's Name/Relationship (7) Celia Bassich/ Da			ng Address (Street a			er, City or Town, State, Md . 21204	Zip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all	int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	emetery, crei	osition (Name of matory or other place Service Co	9)	Date	20c. Location - City of Towson	or Town, State
Balti permit.	Importa eny inju		21. Signature of Fureral Pervice Licens	and the same of th	22	2. Name and Addres Ruck Tows 1050 York	s of Facility Son Funer K Rd. Tow	al Home	: 1ng04	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death one cause on each line.	h. Do not ent	ter the mode of dying	g, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	/sician ledical		Immediate Cause (Final disease or condition resulting in death)	a. LIVER DISE						YEARS
-4,	aminer			Due to (or as a conseq		RT FAILUR	RE			
, D	# 44 A	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq.	uence of):					
xecurity (physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):		_			
8760,	sician e buria	dicai E		d.						
68 Tifficat	as the	0	IE ECHALC.							1
.O. Box 68760, the death certificate be executed	by the attending p tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \Boxed Yes 2 \Boxed No 9 \Boxed Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	elivery Day Year
d ta	gned be de	by Pt	Part II. Other significant conditions co	entributing to death but not res	ulting in the u	underlying cause give	en in Part I.		obacco use contribute	/
ords,	been si should									Probably 4 Unknown
Vital Records, sician: The law requires	ate hes b page 2 s	Completed							osy prior to ormed? death?	
ital	certificat rector, pa	Be Co	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes th (Check only o	-74-	35 220,110
of Vita Physician:	this ce al direc	To	1 Yes 2 Yeo		ER/Outpatie		4 🗆 INGISHING III		dence 6 □Other (Sp	pecify)
C 5	iter ner	tion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	/at <br Yes 2 □ No	28d. Describe l	how injury occurred	
Division Lor Attending	dear ctor: y the	Certification:	2(Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, st y)	reet, factory, office		28f. Location (. City or Tox	Street and Number or I wn, State)	Rural Route Number,
olta	w — —							and due to the	course(s) and manner	no stated
Hospital	s Funstal I			ysician: To the best of my kno liner: On the basis of examina and manner stated.						
To the Hosp	within 24 hours affer To the Funsral Dire completely filled in b	Medical C	(Check only 2 Medical Exam	iner: On the basis of examina		29c. License	oinion, death occur			ue to the cause(s) nth, Day, Year)
To the Hosp	within 24 hours a To the Funeral i completely filled		(Check only 2 Medical Examone)	iner: On the basis of examina and manner stated.	ation and/or in	29c. License D 254	oinion, death occur e number		date and place, and de	ue to the cause(s) nth, Day, Year)
To the Hosp	within 24 hours a To the Funstal is completely filled	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	iner: On the basis of examina and manner stated.	n 23a) (Type,	29c. License D 254	oinion, death occur e number	red at the time,	date and place, and di	ue to the cause(s)

			State of Maryland / Department		•	•	25000
		1	1 - State Registrar Certificate		Reg. N	ZUUb	00375
*	Physici	an	Decedent's Name (First, Middle, Last)	2.	Date of Death Month D	ay Year	3. Time of Death
	/Medic	al	Woodrow Wilson Corbin 4a. Facility Name (If not institution, give street and number) 4b. City, To	own, or Location of Death	January 1	. 2006 c. County of Death	2:30 P ^M
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	6652 Coldstream Drive S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		F. Date of Birth	rederick	-1 (2)
	Funeral Director		214-10-1016 1X M 2 F 93 Yrs. Months	Days Hours Min.	Month, Day, Yea Sept. 27,		place (State or Foreign intry) cyland
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Many a-f aho	tor	Maryland Frederick New Market				1 ☐ Yes 2 🔯 No
	or 284	Director	10e. Street and Number 10f. Zip C	2ode	10g. C	Citizen of What Cou	untry?
	s 23e		6652 Coldstream Drive 21774		USA	14 Page Amer	iona Indian
	fter de	Funeral	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🕅 No	nt of Hispanic Origin? (Specif y Cuban, Mexican, Puerto Ric	can, etc.)	14. Race - Amer Black, White	, etc.
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23e or 28e-f ahow event, the Madical Exacilian minal be notified at	þ	3 Widowed 4 Divorced If Yes, Give 1 Yes 2	No Specify:		Specify: Wh:	ite
15-0	"natu	Completed	15. Decedent's Education 16a. Decedent's Usual (Specify only highest grade completed) (Give kind of work life DO NOT use	Occupation done during most of working retired)	16b.	Kind of Business/I	ndustry
212	within liene r than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	L/Deputy Super		rvland St	tate Police
pu	be filed tal Hygid d other event, I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F			
Maryland		10	William F. Corbin	Rosa May F			
Mar	E a a			Street and Number or Rural F Cream Drive, N			
	s 1 and 2 f Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name	e of Date	eunk 20c.		
Ë	nit. Pages lartment of l ortant: If its injury or o		4 Donation 5 Other (Specify) Mt. Olivet Ceme	eterv	Fre	derick,	Marvland
Baltimore,	permit. Pages. Department of Inportant: If its any injury or of		21. Signature of Juneral Service Licensee. 22. Name and	Address of Facility Keen	ney and Ba	asford Fu	ineral Home
	005 e 0		M00999 106 Eas	st Church Stre	et. Frede	erick, MI	21701 Approximate
	Dhualaisa		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or hear failure. List only one cause on each line. Immediate Cause (Final		espiratory arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Metastatic Colon Cancer Due to (or as a consequence of):	·			18 months
4	Examiner		Sequentially list conditions, b.				
	pet usit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
Ć,	te be executed rsicien and e burial-transit		that initiated events c. Due to (or as a consequence of):				
3760,	w _ w	lical	d				
x 68	leath certificate b attending physic	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			Ond Date of deli-	
Box	death death	Ician	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic preciation in the past 12 months? 1 ☐ Ves. 2 ☐ No. 4 ☐ Pregnant at time of death 5 ☐ Other (spec			23d. Date of delive Month	Day Year
P.O.	that the ded by the detached	hys	9 Unknown				
	res that signed to be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying call	use given in Part I.	23e. Did tobacco		the cause of death? bably 4 Unknown
Records,	w require been sig should b	letec	Coronary Artery Disease		24a. Was an		
Re	a se s	Completed by Physician/Med	Chronic Obstructive Pulmonary Disease		autopsy performed?	death?	opsy findings available ompletion of cause of
ita	ysician: The is certificate hi director, page	ВеС	25. Was case referred to medical examiner?	26. Place of Death (C		10 100	
of \	Physician: this certific ral director,	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA		5 X Residence		rfy)
O	Attending or death.	tlon	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation M	Work? 1 ☐ Yes 2 ☐ No	d. Describe now inj	ury occurred	
Division of Vital	r Atter er dea rector by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office 28f	f. Location (Street a City or Town, Sta	and Number or Rui	al Route Number.
	Hospital or 24 hours afte Funersl Dir tely filled in I						
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29a. Certifier (Check only one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one)	the time, date and place, and n my opinion, death occurred	d due to the cause(at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the complei	Me	29b. Signature and title of certifier 29c.	License number	29d. D	ate signed (Month)	Day, Year)
	d		Junis Elfeelis MD D3	30496	Janu	uary 3, 2	006
1	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	took Emodonds	l. MD 01	1701	
l	Sta	te	Francis E. Becker, MD, 300 West Patrick Str	eet, Frederic	k, MD 21	1701	
1	Registi		31. Date filed (Month, Day, Year) JAN 1 1 2005 32. Registrar's Signature				

016	52	•	1 - For State Registrar	State of Ma	-	•	tment of He		nd Mental Hy	giene Reg. N	とせせじ	0	0376
			1. Decedent's Name (First, Middle, Last)					2. Date of D	eath			Time of Death
	Physici /Medio		Scott Eric Caplar	ì					JANUAR	Υ 6,	2006	10	:44 P M
	Examir		4a. Facility Name (If not institution, give			4	b. City, Town, or	Location of £	Death	40	. County of D		
			ROUTE 175 @ INTERS				ELKRIDGE		U		HOWARI		
	Funeral Director		5. Social Security Number 6. Se 213–13–5083	x 7. Ag ⊋M 2□F	e (In yrs. last birtl 19		If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, D	ay, Year,	9. 1986 Ma	Country)	State or Foreign
	pud 🗼		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Local	ion					10d In	side City Limits
	•ho	ក											☐Yes 2☐No
	28a-1	Director	Maryland Howard 10e. Street and Number		Elkrid	age	10f. Zip Code			10a. Ci	tizen of Whal		
	with Sa or	٥	11895 New Country	Lano			21044			_	J.S.A.		
	me 2;	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Wa	s Decedent of His	spanic Origin	? (Specify Yes or N		14. Race - A		dian,
36	72 hours after death with the Maryland naturel', or Iteme 23a or 28e-f ehow disal Examiner must be rediffied at	by Fur	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		es, specify Cubar Yes 2½ No	Specify:	Puérto Rican, etc.)		Black, W Specify:	/hite, etc. Whit	
Ö	72 hours "naturel", dical Ext	bed	15. Decedent's Edu	ucation	16a. I	Deceden	it's Usual Occupa	ition		16b. H	(ind of Busine		
215	⊆ 2	Completed	(Specify only highest grad	fe completed) College (1-4or t		(Give kin life. DO	d of work done d NOT use retired)	uring most o	f working				
21		E O	Comonary (o 12)	2		ıden	t			Howa	ard Con	munit	y Collec
멀	be filed stal Hygie d other event,	Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle	a, Maidei	n Sumame)		
Vai		To	Roger Caplan					Nancy	Caplan				
lar			19a. Informant's Name/Relationship (T)	ype, Print)	- 1	•			or Rural Route Numb	-			9)
2	s 1 and 2 f Heelth item 27 other tra		Nancy Caplan- moth	er	118	395 I	New Coun	try Lr	n., Columb				
0	8		20a. Method of Disposition 1 Burial 2 Cremation 3 1		i .		on (Name of tory or other place	1			ocation - City		otate
Baltimore, Maryland 21215-0036	t. Pa rtmen rtant:		4 Donation 5 Other (Specify,		Columbi		em. Park		/9/2006	_Co]	lumbia,	MD	
Bal	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licens	600		Wi		eral F	Homes, INC				
			23a Part1 Foter the disease or comp	lications that caused	the death. Do n	55!	55 Twin	Knolls	Rd, Colu	mbia	, MD 2	21,045	roximate
	D		shock, or heart failure. List only one cause on each line.										val Between et and Death
	Physician /Medical		disease or condition resulting in death)	a	a consequence o		Lile	LN.	DICIES			-	
н	Examiner		The second secon			.,.							
		Je.	Sequentially list conditions if any, leading to immediate	b. Due to (or as	a consequence o	ot):							
	cuted	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	С.									
ó	e exec en ar	EX	resulting in death) Last	Due to (or as	a consequence o	of):							
8760,	tate be executed by sicien and the burial-transit	dicat		d									
9	artifica ing ph e as t	Med	IF FEMALE:		10-2								
Вох	eath certific ettending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		ctopic pregnancy				23d. Date of Month	delivery Day	Year
0	t the de by the e teched f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	time of death	5∐ C	ther (specify)					,	
<u>a</u>	that the ed by detection		Part II. Other significant conditions co	nInbuting to death b	ut not resulting in	the unde	erlying cause give	n in Part I.	23e. Did	tobacco	use contribut	e to the cau	use of death?
ds,	uires sign ld be	d by							1 🗆	Yes 2	3□] Probably	4 🗀 Unknown
Ö	v requ been shoul	lete							24a. Wa	s an	24h Were	a autonsy fir	ndings available
Records,	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be deteched for use as the burial-transit	Completed							auto	opsy ormed?	death	1?	ndings available ion of cause of
Vital		0	25. Was case referred to medical					26. Place of	Death (Check only	2□ No	1 1/2	≸es 2□1	NO
<u> </u>	Physicien: this certific ral director,	0 8	examiner? 1 ☑ Yes 2 ☐ No	Hospital:	ent 2 ER/Out	patient	3□ DOA Othe	-	ing Home 5 ☐ Res		6 MOlher (S	Specify) S	CENE
of of		n: T	27. Manner of Death	28a. Dale of Inju	ry 28b. Ti	ime of	28c. Injury Work		28d. Describe	how inju	iry occurred	MASS	FINGE
Division	Attending I r death. ector: After by the funer	Certification:	1 Natural 5 Pending Accident investigation	1/16	26 2	242		es 2 No	OVER		Actor	The	ALRA
N is	r Atte er de recto	tific	3 Suicide 6 Could not be 4 Homicide determined	289. Place of In	ury - At home, far c. <i>(Specify)</i>	m, street	t, factory, office	,	28f. Location City or To	(Street a	nd Number of		
	rs after ral Dire	Cer				MW	My		16761	STAT	£95.19	LKRI	DIRAND
	Hospitel of the same of the sa	Ica	(Check only 20 Medical Exam						lace, and due to the occurred at the time				ause(s)
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one)	and manner st			29c. License						
	T vit		29b. Signature and title of curtifier	1							ate signed (M		,
7	1		, V,		_		OCME	1		JANU	JARY 7,	2006)
11	0 - t		10000	ompleted cause of o			•	BALTI	IMORE, MAR	YLAN	D. 212	201	
	Sta	ato	31. Date filed (Month, Day, Year)	32*Registr	ar's Signature		,		,		-,		
	Regist		JAN 1 1 201	16	100	Casa	ومي						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar aMEND iTEM #20B PER fh 8851 CETTIFICATE Of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** -RANK HOAM DAVELLI 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11204 Cedar Lane Kingsville
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F Months Director 81 02/13/1924 193-16-4763 Pennsylvania Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location r than "naturat", or iteme 23a or 28a-f show the Madical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Baltimore Direct Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11204 Cedar Lane U.S.A. 14. Race - American Indian, Black, White, etc. 21087 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after Yes 2 □No Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed war and Mental Hygier 18 marked other th 12 Assistant Vice President Insurance Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be mit. Pages 1 and 2 should be partment of Health and Menta portant: If item 27 is marked y injury or other traumatic ev Frank T. Davelli, Sr. Mary Cambroto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11204 Cedar Lane - Kingsville, Maryland 21087 ace of Disposition (Name of Date 20c. Location - City or Town, State Norma G. Davelli 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Castleview Castleview Cemetery 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 01/11/2006 New Castle, PA 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee assalw 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEMONAS /Medical Due to (or as a consequence of): Examiner ARKINSONIS 0155ASK Sequentially later any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed 112367ES THE HELL Due o (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ SIP BONE MADE 1 Yes 2 No 3 Probably 4 Unknown Completed MULTIPLE MYELONA 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No TAERTENSION 24a. Was an autopsy performed? 1 Yes 2 0 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only ne Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 7 No this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No d in by the f 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 11/9329 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANES H MSASET NO 6535 N CHAZLES ST BALT, NO 21204
ate filed (Month, Day, Year)

JAN 1 1 2006 31. Date filed (Month, Day, Year)

Registrar

	ŀ	1 - State Registrar		epartment of H Certificate of I	Death	Reg. 1		00378
Physicia /Medic Examino	al	1. Decedent's Name (First, Middle, Last) Emilie Catherine Durant 4a. Facility Name (If not institution, give street and number)	a tru	4b. City, Town, or	Location of Death	2. Date of Death Month January	Pay Year Year 4c. County of Deat N/A	3. Time of Death 204 Q M
Funeral Director		5. Social Security Number 6. Sex 1 M 2X F 86	In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day 04/16/1919		hplace (State or Foreign untry)
ith the Maryland or 28a-1 show	ctor	10a. State 10b. County 1 Maryland N/A	Oc. City, Town o					10d. Inside City Limits 1 XYes 2 □ No
death with the Maryland ms 23a or 28a-f show rrivet be natified at	Funeral Director	10e. Street and Number 3209 Chelsea Terrance 11. Marital Status 12. Was Decedent Event Armed Forces?	er in U.S.	10f. Zip Code 21214 13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spec	U	nited State 14. Race - Ame	es ncan Indian,
LYAN + 1215-0036 within 72 hours after dealone and then "natural", or items ha Medical Examinaring	ρ	1 ⚠ Never Married 2 ☐ Marned 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	16a. D	1 ☐ Yes 2 💢 No	Specify:	16b.	Specify: White Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific	ite
re, Maryland 21215-0036 re, Maryland 21215-0036 s 1 end 2 should be filed within 72 hours after death with the Maryla fileath and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28a-1 show other traumatic event, the Medical Examinar must be notified at	e Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade 17. Father's Name (First, Middle, Last)	- li	Rive kind of work done of the DO NOT use retired	18. Mother's Name	S	ewing Facto	ory
Maryland 212 Maryland 212 d 2 should be filed with th and Mental Hygiens to I is marked other than traumatic event, train	To Be	Julian Eli Durant 19a. Informant's Name/Relationship (Type, Print)		lailing Address (Street	and Number or Rural			
Baltimore, Maryland 212. Permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other treumatic event, tra Means.		Arthur Drager - Attorney 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of D cemetery,	N. Calvert Sisposition (Name of crematory or other place Memorial Parl	Θ) ! Da	te 20c.	, Md 21202 Location - City or *kville, Ma	Town, State
Baltimor permit Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Lansee Charles Mine		22. Name and Address leonard J. Ru	uck, Inc.	5305 Harford Baltimore, I		Approximate
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	onsequence of) Alago onsequence of) Alago	HRTERY	Visea s			Interval Between Onset and Death
376(ate be nysicie	cal	that initiated events resulting in death) Last Due to (or as a c d						
P.O. Bo net the death d by the etten letached for u	Physician/Med	230. Was decement pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Fetal death ne of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deli Month	very Day Year
COTdS, P w requires that been signed t should be deter	۵	Part II. Other significant conditions contributing to death but r	not resulting in th	ne underlying cause give	en in Part I.	23e. Did tobacco	2 No 3 Pr	the cause of death? bbably 4 Unknown topsy findings available
f Vital Rec	Be Completed	25. Was case referred to medical examiner?			26. Place of Death	autopsy performed? 1 Yes 2 2	prior to death?	completion of cause of
Division of Vital Records, to attanding Physician: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be control of the funeral director.	Certification; To	1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 1 Actural 5 Pending (Month, Day Y) 2 Accident investigation 3 Suicide 6 Could not be	ear) 28b. Tim Inju	ry Worl	4 Nursing Hom	3d. Describe how in		
Divisio To the Hospitel or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ledical Certif	4 Homicide determined 200. Flate of mylling building, etc. (29a. Certifier (Check only 2 Medical Examiner: On the basis of ex	Specify) ny knowledge, d	leath occurred at the time or investigation, in my or	ne, date and place, ar	City or Town, Sta	(s) and manner as	stated.
To the Within 22 To the complete	Med	29b. Signatule and title othertifier	a, ra	29c License	number	394 [ate signed (Mont)	Ogy Vogel
Stat Registra	-9	30. Na e and address person who completed cause of deal A A A A A A A A A A A A A A A A A A A	J. 40	pe. Pri t)	nd be	neral	Nespi	tal

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 3:56 AM Doeller, Jr. Dr. Charles Η. JANUARY 8, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nov. | 12, 12, 10 | 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6 Sex **Funeral** 11**∑**]M 2□F Months Marvland 95 220-44-3695 Yrs Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b Counts worle or items 23a or 28s-f show 1 Yes 2 No Parkville MD Director Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. I important: if item 27 is marked other then "natural", or items 23 a or 2, eny injury or other treumatic event, the Medical Executations. U.S.A. 21234 8800 Walther Blvd, #1103 Walden Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1X → es 2 □ No WW II If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Obstetrician Medical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kinnear Doeller, Sr. Florence Charles 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) c/o 929 Corbett Rd., Monkton, MD 21111 Charles H. Doeller, III-son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State 1/12/06 Woodlawn, MD Woodlawn Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lensee 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. William G. Dau 1050 York Rd., Towson, Md Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASPIRATION PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner STAGE IV NON SMALL CELL CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit OF THE LUNG resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2□ No 1 ☐ Yes 1 ☐ Yes 2 💢 No Division of Vital : After this certification of the funeral director, it Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ္ 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospitei or Attending 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funarel Director: completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 25886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21204 OSLER DRIVE, TOWSON. M.D. 7601 ILIA CEBALLOS. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Coarles 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:05 2006 Carrie Edwards January 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Healthcare Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, YO3-15-1906 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1 ☐ M 2 🕏 F 99 Mary land 220-09-8659 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "netural", or Items 23a or 28a-1 show the Medical Examinat must be notified at 1 Yes 2 No Director **Baltimore** MD the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21225 USA 4005 Sixth Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes. Give 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene Important; If Item 27 is marked other than "netural, or lient eny injury or other treumatic event, the Medical Feature 1 Never Married 2 Married 1 ☐ Yes 2XXNo Baltimore, Maryland 21215-0036 3X Widowed 4 □ Divorced USA Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cook 6 Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (John Parks Annie Gray ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4005 Sixth Street Brooklyn, MD 21225 Vanessa M. Davenport/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 01-11-06 Mt. Zion Cemetery Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N.Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UMOM Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Observed or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. attending physicien as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? 1 Yes 2 No 1 Yes R□No Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Other \ ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 70 2 ER/Outpatient 3□ DOA funeral 28b. Time of 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No M 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai (Check only one) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JANUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMERE MO 21201 CEASIAR NORTH EUTAW 32. Registrar's Signature 31. Date filed (Month) State Registrar

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			State of Maryland			ntal Hygiene	006 1	00381
		1 - State Registrar		Certificate of		Reg. No.		
Physic	cian	Decedent's Name (First, Middle, Last) GENNADY		ELGORT	-	Date of Death Month Day		3. Time of Death
/Med	lical	4a. Facility Name (If not institution, give s.	treet and number)		r Location of Death	anualy &	County of Death	1.131 **
Exam	iner		11 01 1 1	20100 17	500000	7	2017, 100	ECP
Funera	1	5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 24 Hrs. 8	. Date of Birth	9. Birthpl	ace (State or Foreign
Directo		217-92-8281	M 2□F 35	Yrs. Months Days	Hours Min. J	Date of Birth (Month Day, Year) UN. 22, 197	0 Count	RUSSIA
pc *		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Location				Od. Inside City Limits
sho	5		IMORE 100. Gity,	OWINGS MILLS				1 ☐ Yes 2 ☑ No
28a-f	Director	10e. Street and Number	THURE	10f. Zip Code		10a Cit	izen of What Count	
er death with the Maryland tems 23a or 28a-f show		4652 RIVERSTONE D	DRIVE, APT. 30		21117	109. 011	2611 OF WHAT COUNT	USA
ter death	Funerai		2. Was Decedent Ever in U.S.	13. Was Decedent of H		ly Yes or No-	14. Race - America	an Indian,
h 2 4		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X			can, etc.)	Black, White, e	
215-UU30 thin 72 hours after 8. en "naturel", or its	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1 Yes 2 No	Specify:		Specify:	WHITE
	Completed	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation du <i>ring</i> most of working	16b. K	ind of Business/Ind	ustry
within 72 ane. then "na	E G	Elementary/Secondary (0-12)	College (1-4or 5+)	MANAGER	J)		WN SHOP	
N B D	ပ္သ	17. Father's Name (First, Middle, Last)		PIAMAGEN	18. Mother's Name (I		11111	
ld be fill ental H ked oth	To Be	LEONID		ELGORT	ALLA		-	ULITSKY
Maryis d 2 should th and Mer i7 le marke traumatic	-	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailing Address (Street		Route Number, City of	or Town, State, Zip	Code)
C = N L		BETH ELGORT / WIF	E	4652 RIVERSTO	ONE DRIVE #	301 - OWI	NGS MILLS	, MD 21117
0 - 7 = 5		20a. Method of Disposition	20b. Placen	ce of Disposition (Name of netery, crematory or other place			ocation - City or Tov	
Pages ment of I		1 X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	SHIOVALITOHI STATE	SINAI CEMETER		2006	OWINGS M	MILLS, MD
Dail Departi Importa eny Inji		21. Signature of Funeral Savice License	0	22. Name and Addre	ss of Facility SOL	LEVINSON	& BROS.,	INC.
10 83558	3	1 gg		8900 REIST	TERSTOWN RO			
		23a. Part 1. Enter the clear the complice shock, or heart fillure. List only on	cations that caused the death.	Do not enter the mode of dyir	ng, such as cardiac or r	espiratory arrest,		Approximate Interval Between
Physician	_	Immediate Cause Final disease or condition	M.I.					Onset and Death
/Medica Examine	_	resulting in dear)	Due to (or as a conseque	- 1 L				
Z.Adillilo		Sequentially list conditions, b	Colonaly		Disease			
ted	Examiner	Sequentially list conditions, if any, seating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	(ince 6/).				
60, be executed sicien and burial-transit	xar	that initiated events c. resulting in death) Last	Due to (or as a conseque	nce of):				
febeev ysicien	cai							
							Ì	
. BOX 58 death certificat a ettending ph) of for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnand			1	23d. Date of deliver	ry
deatl	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of dea		/ 		Month I	Day Year
et the de	hys	9 🗌 Unknown	9□ Unknown					
24	þ	Part II. Other significant conditions con	tributing to death but not result	ing in the underlying cause giv	ren in Part I.		use contribute to the	
w require been signatured by	Completed	Diabetes				1 Yes 2	No 3 ☐ Proba	abiy 4 □Unknown
Hecords, he law requires t e has been signe sge 2 should be	pje					24a. Was an autopsy	prior to com	osy findings available inpletion of cause of
	ပ်					performed?	death?	2 No
Of VITAL HE Physician: The la this certificate ha ral director, page 2	a	25. Was case referred to medical examiner?	ospital:	i Out	26. Place of Death	Check only one		
Phy Parising Billing	P.	1 Yes 2 No	1 Dinpatient 2 El	R/Outpatient 3 DOA 88b. Time of 28c. Injur		5 Residence)
_ 5 9 2	ig I	1 Natural 5 Pending	(Month, Day Year)	Injury Wor	k? Yes 2 □No	d. Describe now inju	ly occurred	
DIVISION of or Attending s after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At hom			f. Location (Street ar	nd Number or Rural	Route Number.
	ert	4 Homicide	building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, State		
To the Hospitel or within 24 hours all To the Funeral Dicompletely filled in		29a. Certifier 1 Certifying Phys	ician: To the best of my knowl	ledge, death occurred at the til	me, date and place, an	d due to the cause(s) and manner as sta	ated.
hs Ho in 24 he Fu pletel	edicai	(Check only 2 Medical Examin	ner: On the basis of examination and manner stated.	on and/or investigation, in my o	ppinion, death occurred	at the time, date and	d place, and due to	the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier	17.	29c. Licens			ite signed (Month, E	
1		Mun Van	W.	H.). D	215/11	1-	8-6	7
4		30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type, Print)	215 111 are Drive	Λ . 1.	4	and Committee
		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	- Fanklin g	are Urive	2 Ibaltin	or mo	21231
Regis	State	ST. Date filed (Month, Day, Year)	oz. Hegistrar's Signatu	Control		•		

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			1		11	Ť
		_	. 4	1.0	3.4	- 1

	148	Funer Direct
MARKSORIE FORD Jaywary 8,2006 000	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel; or Iteme 23e or 28e-f ehow eny injury or other traumatic event, Ite Medical Exercites mostles notified at
		Physicia /Medic

		•	1 - For State Registrar	C	ertificate of Death	Reg.	2006	00382
3	Dhamini		1. Decedent's Name (First, Middle, Last			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Marjorie	Ellen	Ford		06	12:00a M
1	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Deat	
4		(4)-	Gilchrist Nursi		Towson			
1,48	Funeral Director		216-16-6940	x 7. Age (In yrs. last birthda B 3 Yrs.	Months Davs Hours Min.	8. Date of Birth (Month, Day, You 07 15		hplace (State or Foreign untry) MD
	and W	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Aaryli Feho	ŏ	MD NA	Balti	more			1 X Yes 2 No
	28a-	Director	10e. Street and Number		10f, Zip Code	10a	. Citizen of What Co	untry?
	with Be or	₫	4023 Woodhaven	Δνο	21216		U.S.A	•
	death me 23	Funeral	11. Marital Status		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Decify Yes or No-	14. Race - Ame	rican Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "netural; or Iteme 23e or 28e-f ehow event, the Medical Exactinat must be notilised at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	Rican, etc.)	Black, White Specify:	e, etc. Black
Ö	2 hou		15. Decedent's Edu	cation 16a. De	cedent's Usual Occupation	16	b. Kind of Business/	Industry
215	within 7. ene. than "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	ive kind of work done during most of work a. DO NOT use retired)	-		
21	d wit	М	llth grade	na Foo	od Service Worke	r Ci	ity Scho	ol System
ם	be filed ntal Hygi of other event, to	ВеС	17. Father's Name (First, Middle, Last)		18. Mother's Nam	ne (First, Middle, Ma	iden Sumame)	
<u>/a</u>	should be nd Menta i marked umatic ev	70	Charles H. Wath	cins	Nannie	Franklin	n	
lan.	01 65 85 85	v 9	19a. Informant's Name/Relationship (T		ailing Address (Street and Number or Ru			
≥ (C = 01 =				23 Woodhaven Ave			
ore	Section		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ I	cemeten/	sposition (Name of crematory or other place)	Date 20	c. Location - City or	Town, State
Ē	nit. Pages artment of l ortant: If it injury or o		4 Donation 5 ☐ Other (Specify		on Forest Vet. 1	./12/06	Owings	Mills, Md
Baltimore, Maryland 21215-0036	permit. Page Department Important: If eny injury or		21. Signature of Funeral Service Licens		22. Name and Address of Facility March F/H West 4366 Wabash Ave,	Baltimo	ore, Md	21215
	Physician /Medical Examiner		shock, or hear tailure. List only of Immediate Cause (Final disease or condition resulting in death)	a	enter the mode of dying, such as cardiac	or respiratory arrest	t.	Approximate Interval Between Onset and Death
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
68760,	icate be executed physicien end s the burial-transit		resulting in death) Last	Due to (or as a consequence of):				
.89	artificate ing phy e es the	Medical		V				
O. Box	ath ce	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of del Month	ivery Day Year
σ.	that the de led by the a detached i			ontributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds,	signed I	d b				1	2 □ No 3 □ Pr	1 -
Records,	The law require	Completed				24a. Was an autopsy performe	24b. Were au prior to death?	utopsy findings available completion of cause of
of Vital		0	25. Was case referred to medical		26. Place of Dea	1 ☐ Yes 2 € ath (Check only one)		- Ad 110
\geq	Physicien: this certific ral director.	ToB	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2 ER/Outpa		lome 5 Residen		city) Itospic =
ion o	fing After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury 28b. Tim (Month, Day Year) 1nju	e of 28c. Injury at	28d. Describe how		7 () 4 ()
Division	after des Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical C	(Check only one)	ysician: To the best of my knowledge of niner: On the basis of examination and/o and manner stated.	gath crowned at the time, date and place or investigation, in my opinion, death occurrences.	and due to the cau irred at the time, date	ta(t) and marner at e and place, and due	e etated. e to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	l un	29c. License number		d. Date signed (Mont	
1	7 1			completed cause of death (Item 23a) (Ty				

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1

2006

ORIGINAL

32. Registrar's Signature

			State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2 0 0 6 0 0 3 8 3
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physici /Medic		CANALE Foster Day 2006 2025 PM
)	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death VNIV. OF MANYLOND Men Ctr. NIA NIA
Az	Funeral Director	4	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 M 2 F 7. Age (In yrs. last birthday) Yrs. 1 Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 1 T Government 1 T Government 1 T Months 1 T Mont
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Mary a-f eh	tor	MD N/A Battimore 12 Yes 2 No
	h with the 33s or 28	al Director	10e. Street and Number Apt. C 10f. Zip Code 10g. Citizen of What Country? 5704 Lich Raven Blvd USA
36	hours after death with the Maryland ural', or Iteme 23a or 28a-f ehow al Exterioral pencillised at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc: 1 Yes, Sive Year or Dates: 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American Indian, Black, White, etc: 17. Specify: S
21215-0036	d within 72 hours giene. er then "naturel", i the Micdical Exe.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) The Notate 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dimitatic Within Family 16b. Kind of Business/Industry Family 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry Family 16b. Kind of Business/Industry College (1-4or 5+) The Notation Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) Dimitatic Within 16b. Kind of Business/Industry College (1-4or 5+) Col
Maryland 2	be file ital Hy id othe	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lenora Wodson
Mary	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Jones - Sister 3132 Kenym Ave Balto: nd.
Baltimore,	Pages 1 and nent of Healt int: If Itam 2' iry or other		20a. Method of Disposition 1. Burial 2 Cremation 3 Removal from State 4 Dongtion 5 Other (Specify) 20b. Place of Disposition (Name of Camerilla Canada Camerilla Canada Camerilla Canada Canada Camerilla Canada Camerilla Canada Camerilla Canada Ca
Baltii	permit. Pag Department important: i any injury o		21. Signifie of Funeral Service Licensees 22. Name and Address of Facility Street - 2/2/29
			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or many faure. List only one cause on each line. Approximate interval Between
1	Physician /Medical		Immediate Cause (FiMal disease or condition resulting in death) a. Multi System Outan Failure a. Due to (cross stand Death
	Examiner	P.	Sequentially list conditions, T any leading to immediate
	te be executed ysicien and ie burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. NECUM tisc. Due to (or as a consc.) ence of):
8760,	cate be executed obysicien and the burial-transit	dical E	d.
O. Box 6	The law requires that the death certifics ste has been signed by the attending pt page 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
<u>α</u>	w requires that I been signed by should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown
Il Records,	: The law recete has bee	Completed	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No
Vital	Physician: The r this certificate trail director, pag	Be	25. Was case referred to medical examiner? Hospital: 1779es 20 No. Other: 40 Number 40 Positions 60 Position
of	ding Afte fune	tlon: To	27. Manner of Death 1 Sea. Date of Injury 1 Matural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred
Division	or Attendiater death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 6 Could not be determined 1 Homicide 1 See. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Check only one) Check only one)
	To th within To th compl	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
.\			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
4	\		
Z 140	Sta Regist		31. Date filed (Month, Day, Year) 32. Pigistra's Signature JAN 1 1 2006

		1	For State Registrar		State	of Maryla		artment o			lental Hyg	jiene log. No.	006	00381
Phy	/sicia		1. Decedent's Name (First,								2. Date of Dea Month January		Year	3. Time of Death
/M	ledica amine	al -	William Ha. Facility Name (If not instance) 5901 Daybreak		give street and n		ter III		vn, or Location	n of Death	January	4c. Cou	o nty of Death timore	6:40 A
Fune Direc			5. Social Security Number 214-58-5672		Sex XXM 2□F	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Y Months D	ear If Unde ays Hours	Min.	8. Date of Birth (Month, Day May 22,	1951	9. Birth Con Mary	pplace (State or Forei Intry) and
5-UU36 72 hours after death with the Maryland natural, or Items 23e or 28e-f ehow	II Dell		Usual Residence of Deced 10a. State 10b. 0 Maryland	County	imore	10c. C	Baltim							10d. Inside City Limit
ith the	200		10e. Street and Number					10f. Zip Co			1	10g. Citizen	of What Co	untry?
death w	COURT	Funeral Director	5901 Daybreak	Terra	12. Was De	cedent Ever in	U.S. 13.		206 of Hispanic C	rigin? (Sp	ecify Yes or No- Rican, etc.)	US 14. F	Race - Amer	
ours after	EXAMINE	2	1 Never Married 2(3 Widowed 4 Di		Armed F 1 ☐ Yes If Yes, G Year or	2.[X]No Sive		1 Yes, specify			Rican, etc.)		Black, White Books White	
Baltimore, Maryland Z I Z I 3-UU30 semit. Pages 1 end 2 should be filed within 72 hours at Depertment of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or	e Medical	Completed		highest	Education grade completed College	(1-4or 5+)	(Give	dent's Usual O kind of work of DO NOT use r	one during mo etired)	ost of work	ing	16b. Kind o		
IOTE, INICITYICILIU ZIZIO-0000 ges 1 end 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.	ovent, the	Be	17. Father's Name (First, M William Louis F				u	ane opera	18. Mot	her's Nam a Smit	e (First, Middle,			ollinger Root
od 2 should be lith and Mental 27 is marked	treumatic	۲	19a. Informant's Name/Re Patricia Foster	lationship				_	reet and Num	ber or Rur	al Route Number more Mary	-		ip Code)
Pages 1 end nent of Health	ry or other	- 33-	20a. Method of Disposition 1 ☐ Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ O	ation 3		n State	Place of Dispe	osition (Name of matory or other	of r place)	-	Date	20c. Location	on - City or 1	
permit. Pages Depertment of Important: If i	eny inju	1	21. Signature of Funeral S			ton					timore Mar		_	
Physicien and Examination and Diphysicien and Physicien an	ner lisualities	Exa	disease or condition resulting in death) Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s, e	b. — Due to	o (or as a conse	equence of):							Sclay
death certif	teched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregn in the past 12 month: 1 □ Yes 2 □ No 9 □ Unknown		1☐Live	utcome of pregi birth 2 Fe gnant at time of snown	taldeath 3[□Ectopic pregr □ Other (specif					Date of deliment	very Day Year
E B	9	2	Part II. Other significant o	ondition	s contributing to	death but not re	esulting in the u	inderlying caus	e given in Pari	t I.	23e. Did to	A		the cause of death?
The law ate has b	page 2 should	Completed	Care	nos	na		, T	/			24a. Was a autops perfor	sy		opsy findings availab ompletion of cause of
ding Physician: h. Atter this certific	al direct	on: To Be	25. Was case referred to rexaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5	nedical Pending		Inpatient 2 [e of Injury onth, Day Year)	ER/Outpatie		Othor	Nursing Ho	th (Check only or ome 5 PResidence of 28d. Describe h	ence 6 🗆		ify)
or Attending after death. Director: After	in by the fu	Certification:	2 Accident	investigat Could no determin	t be 28e. Plac	ce of Injury - At Iding, etc. (Spec	home, farm, st	М	1 Yes 2	□No	28f. Location (S City or Town		imber or Rui	ral Route Number,
lospite t hours		edical Co	29a. Certifier 12 C (Check only 2 M	artifying adical Ex	caminar: On the	ne best of my kr basis of examination	nowledge, deal nation and/or in	th occurred at to	he time, date a my opinion, de	and place, eath occur	and due to the cred at the time, d	ause(s) and late and plac	manner as ce, and due	stated. to the cause(s)
To the P	comp	Me	29b. Signature and title of	certifier		1 8			cense number			29d. Date sig	,	
, T	-		Wa	ú	Yh X	Jah	00al CF		1203	16		Janu	ary	9,2006
6	Stat	0	30. Name and address of 31. Date filed (Month, Day	No.	Hahr	use of death (Ite	oil h	ch 1	Queen	10	ul B	a de	p	d 2123
Re	gistra	•	JA	N1:	2006	Course	N. A.	buli		,				

		•	For State Registrar	State of Marylan		rtificate of			g. No.	00385
8 a	5 3		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
48	Physicia /Medic		PHYLLIS		F	LAXMAN		JÄNUARY	8, 2006	12:07 P M
-	Examin	er	4a. Facility Name (If not institution, give s			1	or Location of Death		4c. County of Deat	
1	Funeral		4650 ALCOTT WAY 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year		8. Date of Birth	9. Birti	BALTIMORE pplace (State or Foreign untry)
29,	Director		223 00 1030	M 20 F	66 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, JAN. 4, 1	940 <i>Co</i>	MD
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Mary I-f sh	tor	MD BALTI	MORE	OWI	NGS MILLS	5			1 ☐ Yes 2 🔀 No
	or 28s	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	ath w	ral	4650 ALCOTT WAY		_		21117			USA
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other treumatic event, I'm Medical Examinant must be rectified at annex.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ※ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
20	72 hc	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usual Occu kind of work done	pation during most of work	ring 1	6b. Kind of Business/	Industry
121	within ane. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	100		IVE ASSIST		STATE OF M	IADVI AND
d 2	filed Hygie other	Be Co	17. Father's Name (First, Middle, Last)		ADN	TINTOLKATI		e (First, Middle, M	STATE OF Maiden Sumame)	IAKTLAND
lan l	Mental Mental rked o	To B	BERNARD		BET	TELMAN	BELLE			FINE
lary	2 should and Men ie marks eumatic	-	19a. Informant's Name/Relationship (Type						City or Town, State, 2	
	and lealth m 27		ROSLYN NAVIASKY		and the second second second second				LS, MD 211	
Baltimore,	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		osition (Name of matory or other pla TFILOH CE		/2006	Oc. Location - City or WOODLAWN	
Balti	permit. Page Department Important: if eny injury or once.		21. Signature of Funeral Service License		2:	2. Name and Addre	ess of Facility SO	L LEVINS	ON & BROS. IKESVILLE,	, INC.
3	1		23a. Part1 Enter he disease, or comble should or heart failure. List only in	ations that caused the deat						Approximate
	Physician		Immediate Cause (Final disease or condition	myo cand		Infarct				Interval Between Onset and Death
*	/Medical		resulting in death)	Due to (or as a conseq		11000				
- 5	Examiner	_	Sequentially list conditions, b							
	ed	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a conseq	uence oi):					
_^	tificate be executed g physicien and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
68760,	e be e	caiE								
68		Aedicai	15551415							
P.O. Box	The law requires that the death cer ale has been signed by the attendin page 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 DHO 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ideath 3[Ectopic pregnand Other (specify)	ey		23d. Date of deli Month	ivery Day Year
	res that igned b be deta	þ	Part II. Other significant conditions cor hypercly(e) + tho	*	sulting in the c	inderlying cause gr	ven in Part I.		acco use contribute to	
orc	w require been si should I	eted	Myrerconcestero	revolu				1 🗆 Yes		obably 4 Unknown
Division of Vital Records,	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has t completely filled in by the funeral director, page 2	Completed							ed? prior to death?	itopsy findings available completion of cause of
₹	sicie: s certi lirecto	o Be	25. Was case referred to medical examiner? 1 Tyes 2 No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Ot	26. Place of Deat her: 4 ☐ Nursing Ho	h Check only one		-4.1
1 0	Attending Physicien: r death. ector: After this certification of the funeral director, I	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe how	nce 6 Other (Spec w injury occurred	апу)
io	endin sath. or: Aft he fur	atio	1 Accident 5 Pending investigation	(Month, Day 1 dai)	Injury		Yes 2 No			
Divis	after de Director d in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st fy)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,
	Hospital or 24 hours afte Funerel Dir stely filled in	edical C	29a. Certifier (Check only one)	sician: To the best of my knower: On the basis of examina and manner stated.	owledge, dea ation and/or in	th occurred at the to	ime, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title in certifier	and mainer stated.		29c. Licen	se number	29	d. Date signed (Monti	h, Day, Year)
	501		· X/	Goldbloo			3968	Jo	anuary 9	,2006
Ì	2		30. Name an address of person who co		m 23a) (Type) SS 1000	Print) ds Driv	e #400 (owings	mills mi	021117
	Sta Regist		31. Date filed (Month, Day, Year) JAN 1 1 2006	62. Registrar's Signa	ature	des.				

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of H	ealth and Mental Hygiene

	4	For State Registrer	of Maryland / Dep	artment of Healt	th and Mer	•	000	00386
Physicia /Medica Examine	n al	Decedent's Name (First, Middle, Last) WINNIE 4a. Facility Name (If not institution, give street and recommendation).	GILLIAM	4b. City, Town, or Local	tion of Death	Date of Death Month Da Anvary 5		3. Time of Death
Funeral Director		Sinai Hospital 5. Social Security Number 6. Sex 214-26-9606 1 M 2 TF Usual Residence of Decedent	7. Age (In yrs. last birthday 76 Yrs.	Baltime if Under 1 Year If Ur Months Days Hou	nder 24 Hrs. 8	Date of Birth (Month Day, Year) MARCH 5,	9. Birth Cou	place (State or Foreign ntry)
or 28a-f ehow	rector	10a. State 10b. County MD 10e. Street and Number	10c. City, Town or L BALT IMOR		-	10g. Ci	tizen of What Cou	10d. Inside City Limits 1
within 72 hours after death with the Maryland ene. then *netural', or tiems 23a or 28e-f ehow fre Madical Exemitral must be multissed at	ed by Funeral Director	1 Never Married 2 Married 1 Yes,	S 2 TNO Give X Dates:	2123 Was Decedent of Hispanii If Yes, specify Cuban, Me 1 □ Yes 2 □ No Spe			USA 14. Race - Americ Black, White, Specify: BLA	etc. CK
e filed within 72 al Hygiene. I other then "ne went, Ine Madic	Be Completed	(Specify only highest grade complete Elementary/Secondary (0-12) College 10 17. Father's Name (First, Middle, Last)	(Giv. life.	e kind of work done during DO NOT use retired) NISTER	Mother's Name (F.	REL	IGION	
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23s or 28s-f ehov any injury or other traumatic event, It a Madical Examinat must be notified at once.	ToF	ERNEST MOORE 19a. Informant's Name/Relationship (Type, Print) ERNEST G. GILLIAM, JR. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal fro	/SON 11 20b. Place of Disp cemetery, cre	BAILEY LANE, BAILEY LANE, osition (Name of armatory or other place) MORIAL PARK		MILLS, M		own, State
permit. Pa Departme Important any injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Auneral Service Licensee CANCER C.	Joston i	22. Name and Address of F	ST., BA	S A. MORT	ON & SON	S FH, INC
ite be nysicia he bur	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Pulmonary o (or as a consequence of): Aortic do o (or as a consequence of): o (or as a consequence of):	- 1 1.		ispiratory arrest,		Approximate Interval Between Onset and Death
	Physician/Med	in the nast 12 moeths?	gnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of deliv Month	ery Day Year
w requires that the been signed by should be detac	d by	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in F	Part I.			he cause of death?
	o Be Complete	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Other	Place of Death C		prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of 2 12 No
9 9 9	Certification: To	27. Manner of Death 1 Matural 5 Pending (M 2 Accident investigation 3 Suicide 6 Could not be determined	☑Inpatient 2 ☐ ER/Outpatie te of Injury onth, Day Year) Loce of Injury - At home, farm, s Iding, etc. (Specify)	of 28c. Injury at Work? M 1 Yes	28d	5 ☐ Residence Describe how inju Location (Street al City or Town, State	ny occurred	
Tc the Hospital or Attendini within 24 hours after death. To the Funaral Director: After completely filled in by the fun	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To 2 Medical Examiner: On the and m	the best of my knowledge, dea b basis of examination and/or i	ath occurred at the time, dainvestigation, in my opinion,	ite and place, and , death occurred a	due to the cause(s at the time, date an	and manner as s d place, and due t	stated, o the cause(s)
Total Total	M	29b. Signature and title of certifier 30. Name and address of pe son who completed co	M D	29c. License num	000	29d. Da	ate signed (Month.	Day, Year) 5 2006
Star Registra	-	Amy Kingh 1 31. Date filed (Month, Day, Year) JAN 1 1 2006	ause of death (Item 23a) (Type 5 '). Registrar's Signature	ut Hospital	ot b	eltimo	re	21215

		ľ	For State Registrar		State	of Mai	ryland		irtment of I tificate of		d Mental Hy	giene Reg. No.	2006	00387	
			Decedent's Name	(First, Middle, L							2. Date of De	ath		3. Time of Death	
	Physicia /Medic		Aileen Dingman Gillette									9:00a M			
	Examiner 4a. Fecility Name (If not institution, give street					umber)				or Location of De		4c. (County of Death		
			8027 Wate			7 4	(1	4 E '	Elkridg	,	tro la p		ward		
	Funeral Director		5. Social Security Nui 076–38–327	2	Sex 1☐M 2☐vF	54	(In yrs. las	Yrs.	Months Days		Irs. 8. Date of Bir in. (Month, Da May 14	1951	9. Birthi Cou NY	place (State or Foreign ntry)	
	land bw		Usual Residence of D	Decedent 10b. County			10c. City,	Town or Lo	cation					10d. Inside City Limits	
	Mary f sho	ţō	Md	Howard			E1k	ridge	:					1 ☐ Yes 2 ☐ No	
	h the	Director	10e. Street and Number					10f. Zip Code					10g. Citizen of What Country?		
	23a c	alD	8027 Wate	rmill C	ourt				21075			USA			
-0036	d within 72 hours after death with the Maryland jene. I than "netural", or Items 23a or 28e-f show the Works Examination to institled at	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4		12. Was De Armed I 1 Tes If Yes, 0 Year or	Forces? 2 1 No Sive A			Vas Decedent of f Yes, specify Cub □ Yes 2\ No		(Specify Yes or No erto Rican, etc.)		4. Race - Ameri Black, White, Specify: Whit	etc.	
n	72 ho	eted	(Specif	15. Decedent's y only highest o	Education	1)		16a. Deced	lent's Usual Occu	pation during most of	workina	16b. Kin	nd of Business/Ir	ndustry	
7	Mithin ne.	Completed	Elementary/Secondary (0-12)			(1-4or 5+)		kind of work done DO NOT use retire office ma			610	rical		
N	illed Hygi ther nt, t		17. Father's Name (F	irst. Middle. La:	st)				TITCC IIIC	T	Name (First, Middle				
yland	ould be filed Mental Hyg Larked othe	To Be	Howard A.							Joan	(101, 1710010	, maioon i	Somatto,		
ar S	2 should be and Mental is marked reumatic ev	-	19a. Informant's Nar	19a. Informant's Name/Relationship (Type, Print)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Š	and 2 saith a n 27 is		Warren Gi	llette	(spouse) 8			8027	27 Watermill Ct., Elkrid			idge, Md 21075			
ore,	of He of He If item or oth		20a. Method of Dispo		□Removal from	Place of Disposition (Name of cemetery, crematory or other place) All County Cremation 1-					Date 20c. Location - City or Town, State				
gaitimor	tment tent: tent:		`4 □Donation 1	Other (Spec	cify)		A11		-			-	sville,		
n D	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any Injury or other treumatic a one.		21. Signature of Fun			rect		22 P.	. Name and Addr	ess of Facility H 195 Svke	aight Fur sville, N	eral Md 21	Home & 784	Chape1	
	Physician /Medical		23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	failure. List on	y one cause or	CO R).	TRY	_		diac or respiratory a			Approximate Interval Between Onset and Death	
	Examiner		Sequentially list con-	ditions	b										
V	sit s	Examiner	Sequentially list conditions if any, leading to improve cause. Enter Underlicates to interest that initiated avents.	nediate ying	Due t	o (or as a	conseque	nce of):							
	xecution and al-tran	хап	that initiated events resulting in death) La		c	o (or as a	conseque	nce of):							
58/60,	ificate be executed g physician and is the burial-transit	edical E			d										
	rtificat ng ph) as th		IE ECMALE.												
.C. BOX	requires that the death certif een signed by the attending hould be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	onths?		birth 2 gnant al ti	f pregnanc Fetal de me of deal	eath 3	Ectopic pregnand Other (specify)	;y		2	3d. Date of delive Month	ery Day Year	
ords, P	w requires that been signed b should be deta	by	Part II. Other signific	cant conditions	contributing to	death but	not resulti	ng in the u	nderlying cause gi	ven in Part I.	23e. Did 1	,		he cause of death?	
аі кесога	The law ate has b page 2 si	Completed									1 ☐ Yes	psy ormed? 2 No	prior to co death?	opsy findings available impletion of cause of	
Vital	Physician: this certific al director,	o Be	25. Was case referre examiner?		Hospital:	Innation	, 2 TE	R/Outpatien	t 3 DQA Ot		Death <i>(Check only of</i> g Home 5 X lesi			6.1	
O	g Physical this oneral direction		27. Manner of Death		28a. Dat	e of Injury	2	8b. Time of Injury			28d. D scribe			y)	
101	ending Path. or: After in the funera	atlo	1 Natural 2 Accident	5 Pending investigat	ion	Jinii, Day	1041)	mjury		Yes 2 No					
DIVISION	el or Attends elter death	Certification:	3 ☐ Suicide 4 ☐ H <i>o</i> micide	6 □ Could not determine	200. Fla	ce of Injur Iding, etc.	y - At hom (Specify)	e, farm, str	eet, lactory, office		28f. Location (City or To	Street and wn, State)	l Number or Rura	al Route Number,	
	To the Hospitel or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)	Certifying Medical Ex	aminer: On the	he best of basis of e anner state	examinatio	edge, death n and/or inv	occurred at the t vestigation, in my	ime, date and pla opinion, death o	ace, and due to the courred at the time,	cause(s) adate and	and manner as s place, and due to	stated. o the cause(s)	
	To t To t	Σ	29b. Signature and t	itle of certifier	0	0		1	-	se number		29d. Date	signed (Month,		
	,		1 Ken	re E	, Da	K	- /~	J		36371		1 {	6/20	06	
	5		RAYNOA	ss of person wh	o completed ca	Use of dea	ath (Item 2	3a) (Type, 200	Print) 2 McTox	in PAF	exwar ste	670	Anna	21401	
	Sta Registi		31. Date filed (Month	JAN 1 1	2006	Restran	's Signatur	St. A	food		exwar ste				

			For State Registrar	State of Marylan		rtment of H tificate of L			iene 0 0 6	00388
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Ye	3. Time of Death
	Physicia /Medic		AUGUST		G	DELLER		01	08 200	
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Dea	th	4c. County of D	eath
			FOREST HILL HEALTH			FOREST			HARF(ORD
	Funeral Director		217-30-746+	7. Age (<i>in yrs.</i> 1	ast birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min		Year 9.	Birthplace (State or Foreign Country)
	and w	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
	Mary f sho	ō	MA Caril		PONOW	11110				1 ☐ Yes 2 ☑ No
	1 the	rec	10e. Street and Number		-UNUW	101. Zip Code		1	0g. Citizen of What	Country?
	th wit	aD	1531 Doctor Ti	ack Rd.		219	18		//	S.A.
	ems ems	iner	11. Marital Status	2. Was Decedent Ever in U. Armed Forces?	S. 13. V	as Decedent of Hi	spanic Origin? (Specify Yes or No- to Rican, etc.)		American Indian, Vhite, etc.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, It a Madical Examination and be notified a once.	by Funeral Director	1 Never Married 2 Married	1 ∐ Yes 2 2√No If Yes, Give			Specify:	, ,	Specify: /	11/4
Ö	hours tural	d b	3 ₩Widowed 4 Divorced	Year or Dates:	162 Doggd	ant's Havel Occupe	ution		0	UNITE
21215-0036	in 72	Completed	15. Decedent's Education (Specify only highest grade	completed)	(Give I	ent's Usual Occupa kind of work done o O NOT use retired	luring most of we	orking	16b. Kind of Busine	ess/industry
77	with liene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	üle	elder M	lechani	C	Maria	time
ğ	othe othe	BeC	17. Father's Name (First, Middle, Last)		70.0			me (First, Middle, M		
Maryland	uld be Aenta rked tic ev	To E	Carl Shelton F	oxwell			Mary	1 Groeller		
ary	and has me		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street a	ind Number or F	ural Route Number	City or Town, Stat	e, Zip Code)
Z	and and n 27		Cheistopher Gweller	R-SON	1531	Doctor	Jack	Rd., CONO.	WINGO, M	10 21918
ore	of H of H if Iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		lace of Dispos emetery, crem	sition (Name of atory or other place	9)	Date	20c. Location - City	or Town, State
Ē	Pag Iment tant: jury c		`4 □Donation 5 □Other (Specify)		HVIEW	Cremat	CR4 1/	10/06	Dalh mo.	re, mo
Baltimore,	Depart Depart Impor any In		21. Signature of Funeral Service Licenses	9	22.	Name and Address	s of Facility	N FUNER	al Home,	P.A
	40 = e d		Services	- MO1455		2134 C	Illow.	DRING K	d. , 2122	2
	Prrysician. /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death cause on each line.	n. Do not ente	er the mode of dying	j, such as cardia	c or respiratory arre	3St,	Approximate Interval Between Onset and Death
			Immediate Cause (Final disease or condition resulting in death)	caliti	1					
	Examiner			Due to (or as a consequ	uence of):					
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):					
V	uted d ansit	Examiner	cause. Enter Underlying Cause (trease ut if ju y that initiated events							
o,	exec en an rial-tr	Exa	resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	the death certificate be executed y the attending physicien and ched for use as the burial-transit	dical	d.							_
9	artifica ing ph s as t	Med	IF FEMALE:					•		
Вох	eath certific attending p I for use as	lan/	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 	Ideath 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	eath 5□	Other (specify)				
P.O.		P.	Part II. Other significant conditions cont	ributing to death but not res	ulting in the un	deriving cause give	en in Part I.	23e, Did tot	pacco use contribut	te to the cause of death?
Vital Records,	se us	d by	record Luly	,	•	,		1 □ Ye	s 2□No 3□	Probably 4 SUnknown
Ö	v requir been s should	ete	0 T					24a. Was a	n 24h War	a autonov findings available
Rec	The lavate has	Completed	dulen					autops perforr	y prior deat	e autopsy findings available to completion of cause of h?
la		e Co	25. Was case referred to medical				OS Diago of Do	1 ☐ Yes 2	NQ No 1	Yes 2 D-No
	Physician: this certific ral director,	0 0	eyaminer?	ospital:	ER/Outpatien	t 3□ DOA Othe	3	eath <i>(Check only on</i> Home 5 🗆 Reside		Speciful
10			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injun Work			w injury occurred	Specify)
jo	Attending r death. ector: After by the fune	atlo	Natural 5 Pending investigation	(Worth, Day 16ar)	Injury		Yes 2 □ No			
Division of	or Attencifier death	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specifi	ome, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number o	r Rural Route Number,
	ital o urs aft ral Di lled ir	O								
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	edical	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time time estigation, in my of	ne, date and place pinion, death occ	e, and due to the ca surred at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	withii To 11 Comp	Σ	29b. Signature and title of certifier			29c. License		2	9d. Date signed (M	Ionth, Day, Year)
			Daw 5	2		3	2259		JANDAG-	19.2066
	4	18	30. Name and address of person who cor DR. DAVID DUNN,	npleted cause of death (Item 615 W. MACPHA			IR, MD	21014		
	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 1 21	32. Registratives Signal	ture	for the				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** CANOL GRAJES WILAM 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER RANDAUS TOUN HESPITAL Contowes Action If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day) 6. Sex 5. Social Security Number (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** -75-674 1 ☐ M 2 🗸 F Director South arolina Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location itsm 27 is marked other than "natural", or itsms 23a or 28a-1 show other traumatic event. The Medical Examinar must be notified at 10d. Inside City Limits 1 XYes 2 No Director Maryland IMOI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Funeral we Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. 14. Race - American Indian. Black, White, etc. I □ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify þ 3 ☐ Widowed 4 ☐ Divorced a Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Depertment of Health and Mental Hygiene. Important: If Itsm 27 is marked other than sny injury or other traumatic svent, the Ma once. Elementary/Secondary (0-12) College (1-4or 5+) 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be nent of Health and Mental 2 1 19a. Informant's Name/Relationship (Type, Print) (duug hter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 nle . Nd. 2122 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State metery, crematory or other place) 1 ⊠ Burial 2 ☐ Cremation 3 Removal from State 2006 4 ☐ Donation 5 ☐ Other (Specify) arme 22. Name and Address Hapility JOSEPH L. RUSS 2222 W. North Ave 21. Signature of Funeral Service Licensee Funeral Home Balto, Md. 212 2222 23a. Pa ti. Inter the diseare, or complications that cause shock or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) Physician regocar INTAR CTED /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examiner Hospital or Attending Physicisn: The law requires that the death certificate be executed been signed by the attending physiclen and should be detached for use as tha burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b Were autopsy lindings available pnor to completion of eause of death? 24a. Was an page 2 hes certificete 212 No 1 Yes 2 No 1 Tyes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ဥ 1 Impatient 1 Yes 2 ER/Outpatient 3□ DOA this 27. Mann Death 1 Latural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of After 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funersi I 1 Learnifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title 9 29d. Date signed (Month, Day, Year) 29c. License number 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) and ORIANDO CONTINA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar		epartment of Health an Certificate of Death	d Mental Hygie	4000	00390
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	Funeral Director		Bon SE Court 5. Social Security Number 6. Se 7 16 - 56 - 2575 Usual Residence of Decedent		day) If Under 1 Year If Under 24		9. Birthy	place (State or Foreign ntry)
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	s 23a or 26	Funeral Director		IAKNUR	10f. Zip Code 21216		Citizen of What Cour	A
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Daille	permit. Pag Depc.rtment Impc.rtant: any injury once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	191411	22. Name and Address of Eacility JOSEPH L. RUS ZZZZ W. NOCTH	750000	Wings 1 Home, 1 to. Maizi	<u>MISIMA</u> P.A. 216
	Physician		23a. Parvi Enter the disease, or comp ships, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. Do not one cause on each line.		rdiac or respiratory arrest,		Approximate Interval Between Onset and Death
8	/Medical Examiner	jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of Due to (or as a consequence of	DECUB	71		
2/00,	eath certificate be executed attending physicien and for use as the burial-transit	ical Examiner	Cause. Ent. of Josephing Cause (Disease or injury that initiated events resulting in death) Last	c. End He Due to (or as a consequence of d. End Stack				
O. Box 62	ne death certificate the attending phys thed for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliver	ery Day Year
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Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: →Inpatient 2 ☐ ER/Outp		Death (Check only one)	e 6 □Other (Specil	fy)
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	To will	4	29b. Signature and title of certifier		29c. License number D 4 16 TRe. Print) G 4 0 BE (A1)	00 6	Date signed (Month,	200G
)	2		M'L. IRAB	completed cause of death (Item 23a) The CAN M.D. S	GYO BELAI	noloAN A	AL MO	21206
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 1 20	32. Registrar's Signature	Angall B			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 9, 2006 DORIS GREENSTEIN 1:23 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGES' 12411 KINSHIP TURN BOWIE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth DEC. 20, 1932 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1□M 2**∏**F 73 221-20-0601 DE Director Usuel Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show Director 1 ☐YYes 2 ☐ No PRINCE GEORGES' BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 12411 KINSHIP TURN 20715 USA itams 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. 1 Never Married 2 X Marned 0 Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) other then Elementary/Secondary (0-12) **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ie marked LEONARD SUND IDA MAISEL ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth 12411 KINSHIP TURN - BOWIE, MD 20715 RICHARD A. GREENSTEIN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of H Important: if its eny Injury or ott once. 1 Burial 2 Cremation 3 Removal from State BETH EMETH MEMORIAL PARK 1/9/2006 WILMINGTON, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Fureral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease a shock, or heart failure. Us Immediate Cause (Final or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Opset and Death Immediate Casse (Final disease or candition resulting in death) Manti Cell ymphoma **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed nding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 1 No 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 X Natural

2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. neral Director: A filled in by the fi 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral (Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier weine, MD and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestant Read #300 Werner, MD 32. Registrar's Signature Day, Year) 31. Date filed (Month State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 01 08 06 12:05p^M Hernandez /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Stella Maris Towson If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 06 11 Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2X F 217-16-5850 93 Director 12 ΜĎ Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene.
Health and Mental Hygiene.
John Warner of the riber "naturel", or items 23a or 28a-f show ther treatments event, the football for any in a fine football and any in the free contract ovent, the football of the contract of the profittend at 1 Yes 2 No Directo Towson MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Road 21204 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Hace - American Indian. Black, White, etc. 1 Tes PNo fl Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X X No Specity: Specify: X□XWidowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aid Balto School System lýr 12th grade or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Airey Smith ပ Samuel Jabilee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 le eny injury or other treu once. 21209 3006 Temple Gate Road, Baltimore, Md Angelo Hernandez-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriaf 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 1/13/2006 Randallstown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u> 21215</u> Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** RENAL ACUTE FAILURE /Medical Due to (or as a consequence of): Examiner CEREBROVASCULAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit the attending physicien and hed for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) o ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Records, funeral director, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy 2 P No 1 ☐ Yes 2 ☐ No Vital 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Diving Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Naturaf 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ö 1 (E/Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) CHERCIAN CAN D16619 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) CORAZON-VERGARA SOARES, M.D 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Specker Registrar

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HERNAN DEZ

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DHMH 17 Rev 1/2001

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	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examiner must be notified at		Renea Williams-	Daughter	127	West Ea	rle:	igh H	leight	s, S	Sever	na Park, Mc						
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altimore,	그 된 원 중		21. Signature of Funeral Service Licen	<u> </u>	22	. Name and Addre	ss of Fac	ility	2000		.60	0, 110.						
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	ing P	0	27. Manner of Death 1 Z Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui			8d. Describe I	now injury	occurred							
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Division	if or Attanding I after death. Diractor; After 3 in by the funer	Certification:	4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	home, farm, str cify)	eet, factory, office		2	City or To			Rural Route Number,						
ш	ospitai hours e unerai l ly filled		One Conffice ACC vital - PL															
	I 4 II 0	Medical	29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	/sician: To the best of my kiner: On the basis of examinand manner stated.	ination and/or inv	vestigation, in my o	me, date a opinion, de	and place, a eath occurre	nd due to the dat the time.	cause(s) date and	and manner place, and c	as stated. due to the cause(s)						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and marrier states.		29c. Licens	e number			29d. Date	a gigned (Mc	onth, Day, Year)						
	- 3 - 8		-) [mor)					36			110/2							
,	200		30. Name and address of parent into	completed cause of death (to	tom 22a\ /T	Print)		12 10			. , . , .							
,) \		30. Name and address of person who	who have or death (II	(ype,	I A N	D	216	19									
	Sta	te	31. Date filed (Month, Day, Year)	2000 32. Registrar's Sig	nature	freet a		- 7 0	. /									
	Registr		JANII	2008 32. Registrar's Sig	De po	13456												

State of Maryland / Department of Health and Mental Hygiene 06 00396 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 9 JANUARY **Physician** SAMUEL HUBBARD, JR. J. 2006 10:54FM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours **X** M 2 □ F 215-16-7067 86 Yrs. 08-21-1919 MARÝLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location rthen "natural", or Items 23a or 28a-f ehow the Madical Examinar must be notified at 1 ☐ Yes 2XXVio PERRY HALL MD. BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9911 FOX 21128 HILL ROAD U. S. A. 12. Was Decedent Ever in U.S. Amed Forces? XXIYes 2 □ No IYes, Give Year or Dates: W.W.II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: WHITE þ XXWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. College (1-4or 5+) MARTIN MARIETTA COMPANY Elementary/Secondary (0-12) **ENGINEER** YEARS other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth any lighty or other traumatic event popes. HUBBARD, SR. SAMUEL J. EMMA GERTRUDE ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SON) DAVID C. HUBBARD 9911 FOX HILL ROAD, PERRY HALL, MARYLAND, 21128 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 Cremation 3 Removal from State DULANEY VALLEY MEM.G. 01-13-2006 TIMONIUM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service-Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 (R.G.RUTH) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) VENTILATORY FAILURE HOURS /Medical Due to (or as a consequence of): Examiner SEPIS DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner as the burial-transit EMPYEMA 2 WEEKS and resulting in death) Last Due to (or as a consequence of): Box 68760. physician ESOPHAGEAL-PLEURAL FISTULA 2 WEEKS Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No Records, P.O. 9□ Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown SEVERE MALNUTRITION Completed peen 24b. Were autopsy findings available prior to completion of cause of death? PNEUMONIA 24a. Was an has autopsy performed 2 No 1 Yes 2 No 1 Yes Division of Vital Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: ours after deau.

A Director: An.
in by the fur 1. Natural 5 Pending М 1 Tes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Dia Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifie D35453 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 INDA BARR M. D. 7601 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 2006 Registrar

			1- State of Maryland / Dep	artment of Health and Mi rtificate of Death	ental Hygie	Z11116	00395
*	1 2 M	ij ş	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Anna E. Hyland		January	7 2006	1:00 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) Berlin Nursing & Rehab Center	4b. City, Town, or Location of Death Berlin	7	4c. County of Death Worchester	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday $217-14-3697$ $1 \square$ M $2 \cancel{X}$ F 83 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 09/25/19	earl Cou	place (State or Foreign nitry)
*	<u> </u>		Usual Residence of Decedent				
	arylar	٦	10a. State 10b. County 10c. City, Town or L			1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	MD Mariora Whitehall	10f. Zip Code	10a	. Citizen of What Cour	
	Sa or		5139 Jolly Acres Rd.	21161		USA	,
	death ms 2:	Funeral		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Americ	
Maryland 21215-0036	72 hours after death with the Maryland "natural", or Items 23e or 28e-f show idical Exeminational be inclified at	þ	1 Never Married 2 Married 1 Yes, 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	rican, etc.,	Black, White,	
5-0	72 ho	eted	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	ng 16	b. Kind of Business/In	dustry
121		Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		G0000000	
d 2	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)	Intant 18. Mother's Name	(First, Middle, Mai	seagrams iden Sumame)	
au	should be filed within and Mental Hygiene. Is marked other than umatic avant, Its Man	To Be	Earl T. James	Helen Mo	rtimer		
ary		-	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ng Address (Street and Number or Rura	l Route Number, C	City or Town, State, Zip	Code)
	Health a tam 27 la			Jolly Acres Rd., W			
Baltimore,	Pages 1 are nent of Hearn if item		1 XBurial 2 Cremation 3 Hemoval from State	matory or other place)		c. Location - City or To	own, State
Ħ	그는 한 근 .		4 Donation 5 Other (Specify) Modowride 21. Signature of Funeral Service Licensee	Mem Park 01/11/02. Name and Address of Facility	06 E1	Jkridge, MD	
Ba	Depa Impo any i		MO1378 7	ary L. Kaufman Funeral ! 250 Washinoton Blvd. E	Ikridae M	21075	
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the control of the cause	Cerdia a saler /	Commentation arrest		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
		e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
		Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
oʻ	ate be executed only sicien and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
8760	the the	dicai	d				
Box 6	ie death certifica the ettending ph hed for use as the	Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
P.0	thet the d ed by the detached	Ph	9 Li Unknown	and a bitan and a second in Daniel	330 Did tobor	non una contributa ta t	he sauce of death?
Ś	w requires the been signed should be det	ed by	Part II. Other significant conditions contributing to death but not resulting in the	underrying cause given in Part I.		cco use contribute to t 2 ☐ No 3 ☐ Prot	
Vital Record	has has	Completed			24a. Was an autopsy performe	d? death?	opsy findings available impletion of cause of
ital		BeC	25. Was case referred to medical examiner?	26. Place of Death			
of V	Physicien: this certific ral director,	2	1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			e 6 ☐Other (Special	b)
	ding P	lon:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division	or Attanditer death	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
	To the Hospitel of within 24 hours ef To the Funeral D	edical Ce	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place any prestigation, in my opinion, death occurre	and due to the cause	se(s) and rianner as s	itated
	o tha hithin 24 o tha Formplete	Medi	one) and manner stated. 29b. Signatura and title of certifier	29c. License number		. Da e signed (Month,	
	- 5 - 5		11/18 Well is	7 09876	9 1	18/06	
9	5 '		30 from and address of person who completed cause of death (Item 23a) (Type Nicho a Bonaduelia)	109 Coastel His	uy Fa	not Falen	1 De 19941
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 2006 2. Registrar's Signature	Salle of the sale			

				State of Maryland / Depart	artment of Health and N	-	•	00000
			Registrar	Cei	rtificate of Death	Reg.	No. CUUD	3. Time of Death
	Physici /Medic	al	Decedent's Name (First, Middle, Last) Daniel Joseph Ja. 4a. Facility Name (If not institution, give si		4b. City, Town, or Location of Death	January	Nonth Day Yeer	
	Examir	er	7130 Gough Stree		Baltimore		Baltimor	e Co
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthy	place (State or Foreign
	Director	1	Usual Residence of Decedent	M 2□F 72 Yrs.		4-14-193	33 Mar	yland
	show	'n	10a. Slate 10b. County	10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the N	Director	MD Baltimor 10e. Street and Number	e Co. Baltimo	r e 10f. Zip Code	10g.	Citizen of What Cou	
	th with	a DI	7130 Gough Stree	t	21224	US	SA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 Is marked other than "netural; or Items 23a or 28a-f show other traumatic event, If a No 15a Exact in errorat be notified at	Completed by Funeral	11. Marilal Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ᢂ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	etc.
21215-0036	nin 72 hou in "netura Maalgal E	pleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation 16a, Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b	Whi. Kind of Business/In	
212	filed with Hygiene other tha ent, IVE	Com	12		1 Worker		nerican	Can Co.
and	ould be file Menta! Hy arked oth atic event	Be	17. Father's Name (First, Middle, Last)	a l- <i>i</i>		e (First, Middle, Maid	den Sumame)	
Maryland	should and Men s marke umatic	은	Nickolas Jagodzi		VIOLA K	Kucinski al Route Number, Cil	tv or Town. State. Zir	Code)
	nd 2 sho alth and 27 Is m r traum		Mary Jane Jagod		Gough Street E			·
Baltimore,	es 1 a of Hez fitem r othe	3	20a. Method of Disposition	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	Date 20c.	. Location - City or To	own, Slate
Ë	Page: ment o ant: If jury or		1 Burial 2 Cremation 3 Re '4 Donation 5 Other (Specify)		nislaus Cem 1-1		altimore	
Ball	permit. Pages 1 and. Department of Health Important: If item 27 eny injury or other tr once.		21. Signature of Funeral Service License		2. Na <i>m</i> e and Address of FacilityKac 201 Duridalk Ave			and the same of th
	Physician / Medical / Medical support of the spring from the support of the suppo	Examiner	23a. Part1. Enter the disease, of implication shock, or heart failure. Limit only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause Enter Under in Cause (Disease or Injury that initiated events resulting in death) Last	cations that caused the death. Do not enter e cause on each line. CARDIDM Due to (or as a consequence of): Due to (or as a consequence of):	SOURCE SHOWS AND THE REST TO SERVICE SHOWS	or respiratory arrest,		Approximate Interval Between Onset and Death 3 Weck
O. Box 68760,	death certifica e attending phi d for use as th	Physician/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year
s, P.O	requires that the een signed by th hould be detache		Part II. Other significant conditions con	•	. , , ,	23e. Did tobacc	co use contribute to t	
ords	w require been sig should b	ted k	PROGRESSIVE	SUPRANUCLEA	FR PALSY	1 Tes	2 No 3 Prot	pably 4 Minknown
Il Records,	The law ate has b page 2 sl	Completed by				24a. Was an autopsy performed 1 ☐ Yes 2 🔀	prior to co death?	opsy findings available impletion of cause of 2 No
Vital	Physicien: The this certificate ial director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospitał: 1 □ Inpatient 2 □ ER/Outpatie	Othor	h (Check only one)	0 Flore /0	6.1
of		H	27. Manner of Death	28a. Date of Injury 28b. Time of	11 3 DOX 4 Nuising He	ome 5 Residence 28d. Describe how in		Y)
Division	or Attending I after death. Director: After in by the funer	Certification:	1 Xatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) Injury 28e. Place of Injury - Al home, larm, st building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St		al Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Examin	sician: To the best of my knowledge, deat her: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, evestigation, in my opinion, death occur	and due to lhe cause red at the time, date	e(s) and manner as s and place, and due t	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month,	Day, Year)
			David Silv	ren DO.	Н 43234	Jan 9, 2006		
	6+1		Dr. David Silv		Print) n Ave. Baltimor	e, Maryl	and 2122	24
	Sta	ate	31. Date filed (Month, Day, Year)	32. Rastrar's Signature	(mest)			

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death KEDZIERSKI, JR 04 Month K EOWARD 0434AM 06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CONTER BALTIMORE, MD NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Days 1**©**M 2□ F 212-56-9949 27 1950 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits NIA 1 Tes 2 No Baltimor Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 91991 USP 52 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Whit Specify: δ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) onstruction 8 th abover 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ed Ziers Ki 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Date Bolto 2 Location - City or Town, State 529 daughter 21294 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metro 111506 4 ☐ Donation 5 ☐ Other (Specify) remotor 21. Signature of Juneral Service 🖟 22. Name and Address Facility PA 18434 AM 1232 Midvalla, Dr Dessur ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final MYO COLRIDIAL NEXT CTION disease or condition resulting in death) Due to (or as a consequence of) DISEASE CORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 JUnknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 P/Outpatient ဥ 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

deeth with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any njury or other treumatic avent, the Macical Examiner must be notified at once.

Physician

/Medical

the attending physicien end thed for use as the burial-transit

Examiner

Baltimore, Maryland 21215-0036

this certificate has been signed by the atternation of director, pege 2 should be detached for To the Hospital or Attending Physician: within 24 hours after death.
To the Funerel Director: After this certifica filled in by the

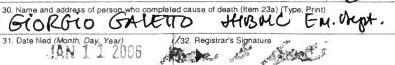
funeral director,

Certification:

Medical

State Registrar

31. Date filed (Month, Day, Year)



(Check only one) 29b. Signature and

29c. License number

39211

29d. Date signed (Month, Day, Year) 10/06

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		1 - For State Registrar		•		rtificate of				Reg. No.	UUb	00398	3
Dhuois	ion	1. Decedent's Name (First, Middle,	Last)						2. Date of Dea Month	ith Day	Year	3. Time of Death	
Physic /Med			ERS KINAR						January	7	2006	13:43 M	<u> </u>
Exami	ner	4a. Facility Name (If not institution,				4b. City, Town,		of Death			ounty of Death		
Funera		UPPER CHESAPEAK 5. Social Security Number		CENTER '. Age (In yrs. la		BEL If Under 1 Year	If Under		8. Date of Birth	h -	ARFORD (CO lace (State or Foreign try)	n
Director		250-66-1391	1 □ M 2 XX	67	Yrs.	Months Days	Hours	Min.	(Month, Oa) MAR 4	1938	SOUT	H CAROLINA	Į.
pu s		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation					1	Od. Inside City Limits	_
Maryli f sho	ō		TODE GO	,							1	1 ☐ Yes 2X No	
r 28a-	Director	MARYLAND HAR 10e. Street and Number	FORD CO		EDG.	EWOOD 10f. Zip Code				10g. Citize	n of What Cour	itry?	_
death with the Maryland ma 23a or 28a-f show rmast be notified at		1911 HARBINGE	R TRAIL			2104	0			U.S	5.A.		
r dea	Funeral	11. Marital Status	Armed Ford		13.	Was Decedent of f Yes, specify Cut	Hispanic Or pan, Mexica	igin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
s afte	by Fu	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 2 If Yes, Give Year or Dai)	i	1 □ Yes 20XNo					pecify: BLA		
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Z should I and Meni is marke	2	ARTHUR BOWERS 19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailir	ng Address (Stree	1		BOWERS		own State Zin	Code)	
and 2 s and 2 s satth ar n 27 is		Ralph E. Kinard		and		Harbing							
es 1 a of Hez	-	20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of natory or other pla			ate		tion - City or To		
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Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition	nry one cause on ea	ch line.	t,	RENAL	CA	411 (1	RE			Approximate Interval Between Onset and Death	
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aw re	ompleted	440	ERTEN	TION					24a. Was a		Were autor	osy findings available	•
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JII OI VIIA Jing Physician: After this certific funeral director,	P	1 ☐ Yes 2 ☐ No		patient 2 E		1 3 DOA					Other (Specify	')	
ding Phys	ion	27. Manner of Death 1		Day Year)	28b. Time of Injury	Wo	ıryat ork? ∃Yes 2.⊟		8d. Describe h	ow injury o	ccurred		
Attence death death octor:	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of	of Injury - At hon	ne, farm, str	eet, factory, office		-			lumber or Rura	Route Number,	-
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier Certifying (Check only one)	Physician: To the base caminer: On the base and manner	sis of examination	vledge, death on and/or in	occurred at the t vestigation, in my	ime, date an opinion, dea	nd place, a oth occurre	nd due to the c d at the time, d	ause(s) an late and pla	d manner as st ace, and due to	ated. the cause(s)	
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 () () 6 00399 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LINDENBERG Year GERALD **Physician** DNJARY 09 OTIT AM 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** BALTIMORE 8 AYU rew JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Lugust 17, 1939 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F Days Hours Yrs. 13-36-0497 66 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or Items 23s or 28e-1 show treumatic sysht, the Medical Exeminat must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3402 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any injury or other treumatic avant, tha Medical Examinat must appea. 21222 DENWALL by Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ္က UNKNOWN FRANCES LINDENBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3402 Rd. Date 20c. Location - City or Town, State R. Lindenberg DRNWall ave 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 (**Cremation 3 ☐ Removal from State Balhmore, MD 04 4 ☐ Donation 5 ☐ Other (Specify) ayview rematery 21. Signature of Funeral Service Ligensee

22. Name and Address of Facility

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1 Home 21222 Immediate Cause (Final Renal **Physician** Acute Failure 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ba desenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Portal Hyperter Due to (or as a consequence bi): that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown per lipido 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☑ No certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. 925299 Brunny Dean Dalile 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS DALILI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 0.0400Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year <u>Frances V. Lastner</u> 8, /Medical 2006 Jan. 8:15 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare- Heritage Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 1 F Director 217-09-5936 91 12/14/14 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Intern of Heatth and Mental Hygiene. Int: If item 27 is marked other then "natural", or items 23e or 28e-f show 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ral', or items 23e or 28e-f shov Examiner aust be nutified at Completed by Funeral Director 1 XYes 2 □ No Md n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 318 S. Wolfe Street 21231 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Specify: White other treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembly Shoe Factory 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ပ Francis Frazier Josephine Kowalewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6922 Delvale Place <u>Eugene J. Lastner, Sr.</u> Dundalk, Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Importent: If ite any injury or ot once. 1) Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) St Stanislaus 1/12/06 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facil
Kaczorowski Funeral Home P.A. 1201 Dundalk Ave. Baltimore. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List griy one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ABFTES **Physician** MELLITUS disease or condition resulting in death) /Medical uence of):

SCLEROTIC CARDIO VASCULAR

uence of):

DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day 4☐ Pregnant at time of death Year P.O. | 5 Other (specify) 9□ Unknown n signed by tt. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No Completed 3 Probably 4 Danknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Ursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after of Funerel Direc Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

				1 - For State Registrar	State of Ma	arylan	d / Depa <i>Cer</i>	rtment of F	lealth and M Death		Eug L	006	004	101
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		Examir	ner	HOSPICE OF BALTIM		RIST	CTR.	4b. City, Town, o	TOWSON		4c. Cou	nty of Death RALT	IMORE	
		Funeral Director		5. Social Security Number 6. Se			ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da NOV . 22	th y, Year) 1912		place (State on POLAN	r Foreign
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040511		ith the M or 28a-f	Funeral Director	10e. Street and Number			DITE	10f. Zip Code			10g. Citizen o	of What Cou	ntry?	
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0	980	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23e or 28e-f show the Medical Examinar must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:		11	vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	- 14. P 8	lace - Americ llack, White, cify:		Ξ
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Co	Maryland	2 should be to and Mental Is marked of raumatic eve	^L	19a. Informant's Name/Relationship (T)	rpe, Print)		HERSHI		ESTHER and Number or Rura	d Route Numbe	er. City or Tow		NSBERG	
1		and 2 lealth a m 27 is		ESTHER LICHTENBE	RG / DAUG	HTER			EE CIRCLE					
	Jore	ages 1 ar nt of Hea : If item :		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	lemoval from State	CE	metery, crem	ition (Name of atory or other place	e)	Date	20c. Location			
4	Baltimore,	permit. Pages Department of I Important: If ite any injury or of		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service (Cens	96	FURI		METERY Name and Addres	01/10 ss of Facility SOI	0/2006		SEDALE	-	
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4	ion	Attending Physician: r death. sctor: After this certifice by the funeral director, i	ation	1 Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day	Year)	Injury	28c. Injury Work M 1 🗀 Y	res 2 □No	ou. Describe ii	ow injury occi	mea		
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SE		Hospitel or 24 hours afte Funerel Dir tely filled in		29a. Certifier 1 Certifying Phys	ician: To the best of	my know	ledge, death	occurred at the tim	e, date and place, a	nd due to the c	ause(s) and m	nanner as st	ated.	
		the H	Medicai	one)	and manner state	axamman	on and/or inve	istigation, in my op	inion, death occurre	d at the time, d	late and place	, and due to	the cause(s)	
4		To Your		29b. Signature and title of certifier	e b	1 ()		29c. License		2	Jan,			
	1	7		30. Name and address of person who co				rint)	· · · · · · · · · · · · · · · · · · ·			2017	006	
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		•	For State Registrar	State of Maryland		ment of Health and ficate of Death		giene Reg. No.	2006	00402
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_	Examin Funeral Director		4a. Facility Name (If not institution, give s 16487 Ed Warfiel 5. Social Security Number 217-09-5335A		WC	odbine f Under 1 Year If Under 24 Hr Ionths Days Hours Mir	s. 8. Date of Birt	Ho	ward	place (State or Foreign
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locat	ion	3/30/1			10d. Inside City Limits 1 ☐ Yes 2 No
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examination that invalided and once.	To Be Completed by Funeral Direc	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last) Villiam Francis 19a. Informant's Name/Relationship (Ty)	2. Was Decedent Ever in U.S Armed Forces? 1 □ Yes, 2 □ No If Yes, Give Year or Dates: accompleted) College (1-4or 5+) Feeney De, Print)	13. Wa If Y. 1 II 16a. Deceden (Give kin life. DO HOMEMA	18. Mother's N Anna Wo Address (Street and Number or N	Specify Yes or Norto Rican, etc.) orking ame (First, Middle, 11fe	Uni 16b. Kir Her Maiden	Town, State, Zij	ates can Indian, etc. ite idustry
Baltimore, M	permit. Pages 1 and 2 Department of Health Important: if item 27 i any injury or other tra 2009.	3	Anne Bradford (D 20a. Method of Disposition POBurial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State 20b. Pic ce EMO1	nce of Disposition of	ory or other place)	Date /2006 rrier-Q	Jppe uee	erco, M n Fune:	own,State 1D ral Home
8760,	death certificate be executed Wedical Examine of attending physician and for use as the burial-transit	ical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, frany, leading to intinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	ence of):	Infarction		rest,		Approximate Interval Between Onset and Death Week
P.O. Box 68	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of decent	death 3□Ed	etopic pregnancy ther (specify)		2	3d. Date of deliv Month	rery Day Year
	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	•	iting in the unde	orlying cause given in Part I.	23e. Did to			the cause of death?
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of	Phys this al di	To B	examiner? 1 Yes 2 No F 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		R/Outpatient 28b. Time of Injury	Othor	Home 5 PAesic 28d. Describe h	lence 6		fy)
Division	in Sign	ai Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)		, factory, office	City or Tou	n, State)		al Route Number,
)	To the Hospital within 24 hours a To the Funeral I completely filled	Medical				29c. License number	curred at the time, o	date and 29d. Date	place, and due to signed (Month,	to the cause(s)
	Sta Registi		30. Nam- and address of person who so Richard G. 31. Date filed (Month, Day, Year)	meted cause of death (Item STERNACC') 32. Registrar's Signate	D.0	3250 Startin			100	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2006 a **Physician** January 6, James Kent Millard 5:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 113 New Castle Court Frederick Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Jan 26, 19 5. Social Security Number 6 Sex **Funeral** Days Hours Min 1**⊠**M 2□F 216-40-7967 63 Yrs. 1942 Washington, DC Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or iteme 23a or 28e-f ehow the Medical Examinar next be notified at Frederick Frederick Maryland 1 X Yes 2 ☐ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 113 New Castle Court U.S.A. deeth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status tiled within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 N Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specity: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Ass't Manager Auto Body Shop 12 . Pages 1 and 2 should be tiled w iment of Health and Mental Hygie tant: if item 27 is marked other t jury or other treumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Addison Millard Ruth Corle James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 New Castle Court, Frederick, Maryland 21702 Mrs. Yvonne Millard, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: if any injury or once. Smithsburg Crematory Jan 7,2006 | Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Keeney and Basford PA Funeral Home M00706 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE 2415 **Physician** LIVER /Medical Due to (or as a consequence of): Examiner cirritosis 6 41) organization is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 No 1 🗌 Yes 2 / H To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Tresidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 (Vatural 5 Pending investigation To the Hospitei or Attendin within 24 hours after death.
To the Funerei Director: Af completely tilled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 2 Medical Examin 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-31912 January 6, 2006 VV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JULIO MENOCION MO - 1564 opossumoun Plus MEDEMIN MD ZITUR 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 JAN 1 1 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Year **Physician** 1005 AM Irene McSorley lanuary Anne 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Co. Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year Days Hours 1 □ M 2 1 1 1 Yrs. Illinois 21.1923 Director 353 18-6823 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If Item 27 is marked other than "natural," or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show treumatic event, its Mudical Examinant minist to notified at 1 Yes 2 No Director Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21783 120 Bachtell Circle U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify: þ 3. Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Prince George's Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Human Resources 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Ralph Seidler Tracy 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or othar tree Merry Jo Riley (Daughter) PO Box 775446 Steamboat Springs CO 80477 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Januarte 10. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2006 Maryland Veterans Cem. 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licensee when D. Dileles 6633 Old Alexandria Ferry Road Clinton, MD20735 mo1284 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has autopsy performed? /es 2 10 No 1 Yes or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; After Injury 1 Matural 5 ☐ Pending death. 1 □ Yes 2 □ No investigation 2 Accident the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours efter To the Funerel Dire Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the ! 29b. Signature and title of pentile 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) /0 contro 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006 DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and M 1- State Registrar Certificate of Death	lental Hygie	^{ene} 2006	00405
				2. Date of Death	. No.	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last) Esther Lois Widmer Nye	Month	Day Year	
	/Medic			January		11:00a ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
			6803 Carroll Highlands Rd. Sykesville		Carroll	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthpl	ace (State or Foreign
	Director		196-03-4H78 10 M 28 100 Yrs. Months Days Hours Min.	July 27	1905 PA	
	P.		Usual Residence of Decedent			A talle or their
	irylai thow	_	10a. State 10b. County 10c. City, Town or Location		"	Od. Inside City Limits
	e Ma	cto	Md Carroll Sykesville			1 ☐ Yes 2 ☐XNo
	th th or 28	ire	10e. Street and Number 10f. Zip Code	100	Citizen of What Coun	try?
	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "natural", or Itama 23a or 28a-f show event, If a Modical Examiter must be muffled at	Funeral Director	6803 Carroll Highlands Road 21784		USA	
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au	id be enta ked ic ev	To B	John Christian Widmer Verena	Jaggi		
3	shour or Mark	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	al Route Number, (City or Town, State, Zip	Code)
Maryland 21215-0036	s 1 and 2 should f Health and Men tem 27 is marke other traumatic		Margie Nye Domer (daughter) 6907 Ridge Rd., Sy	rkogwill	MA 21'	704
e,	as 1 and 2 of Health I item 27 I		20a Method of Disposition 20b. Place of Disposition (Name of		c. Location - City or To	
ō	in it of or o		1 Burial 2 Cremation 3 Removal from State			
Ë	Pa tmer tant jury				ykesville	
Baltimore,	permit. Pages i Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ha	ight Fu	neral Hom	e & Chape
ш	405 g d		P.O. Box 195 Syk	esville	Md 2178	4
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Approximate Interval Between Onset and Death
68760,	tificate be executed g physician and as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.			
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Ö	v requii been s should	Completed		24a. Was an	24h Word autor	sy findings available
ě	e lav has	dи		autopsy	prior to con	pletion of cause of
=		S			ZNo 1 ☐ Yes	2□ No
Vital	Physician: Th this certificate ral director, pag	Be	examiner?	h (Check only one)		
of	S : D	70		ome 5 Resident	ce 6 ☐Other (Specify)
	ding Pl		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work?	28d. Describe how	injury occurred	
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Ö	al or after after I Dira	Certification:	4 Homicide building, etc. (Specify)	City of 10411,	State)	
	spitu nours nora	aic	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the caus	se(s) and manner as st	ated.
	To the Hospital or Attanding Phwitin 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred one)	red at the time, date	and place, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number	290	I. Date signed (Month, I	Day, Year)
	F S F 0		1 Rock 1. When und 0320000	-	1/9/2	6
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	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	· D.	Reis forms	Len MI
			and Device the Company of Company	1000		, , , ,
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registr		JAN 1 1 2006 Month, Day, Year)			
DH	MH 17 Rev 1/2	001	·			
			ORIGINAL			

Darius Jan Paliwoda Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#2a,2/,22a-f,penf.,001,1/2/00 II 06-0056 Amend item#32a, perile, 3853,3/22/06 Certificate of Death

Reg. No. 1 - For State Registrar Reg. No. 4 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Paliwoda Darius 6:37 P M Jan January 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 7113 Ridge Road Hanover | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. 03/09/1982 Birthplace (State or Foreign Country)
 Poland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 213-11-1198 23 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or iteme 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Hanover Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21076 United States 7113 Ridge Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status i filed within 72 hours after dail Hygiene. other than "natural", or item Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automobile Collision Mechanic 12 and Mental Hygin 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Iwona Ladon Ireneusz Paliwoda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1624 Sage Brush Court Severn, Maryland 21144 item 27 Ireneusz Paliwoda - Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 0 = 1 ■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if any injury or once. Holy Rosary Cemetery 01/07/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MEthadone intoxication Approximate Interval Between Onset and Death MEthadone intoxication Immediate Cause (Final **Physician** Narcotic Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine anding physicien and use es the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? certificete 2□ No 1 X Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene 1X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury Fini (Month, Day Year) 28b. Time of Fini Injury 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No P^{M} 1/2/2006 6:26 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7113 Ridge Road 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide unk To the Hospital within 24 hours a To the Funeral D Hospital Hanover, MD TEL Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2CXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 ABILLEATH 31. Date filed (Month, Dey, Year) Registrar's Signature State Registrar 2006

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		1	For State Registrar	State of Maryla		artment of rtificate of		nd Mer		giene Reg. No.	2006	004	0
	siciar edica		Decedent's Name (First, Middle, Las	•					Date of Dea Month	Day	2006	3. Time of Dea	ath M
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or Items 23a or 28a-1 show minportant; if them 27 is marked other than "natural", or Items 23a or 28a-1 show any hitury or other fraumatic event. It shedice Examinat the notified at) lessen	1	3605 Granite Ro 1. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	2116 Was Decedent of If Yes, specify Cu	Hispanic Origin ban, Mexican, f	n? (Specify Puerto Ric	y Yes or No an, etc.)	Uni	ted St 14. Race - Amer Black, White Specify: Wh	ates ican Indian, , etc. ite	
Maryland 21215-0036 to 2 should be filed within 72 hours at the and Mental Hygiene. T? Is marked other them 'naturel', or 'requirentle event.' Headles	potologic	Paradilli	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	ident's Usual Occu s kind of work done DO NOT use retir	during most o	of working			nd of Business/l	ndustry	
aryland 2 should be filed and Mental Hygie marked other		b 1	12th 7. Faither's Name (First, Middle, Last) Clarence Higgs		⊥_Hom€	emaker	18. Mother's			Maiden			
and 2 sho ealth and 1 m 27 is me		1	9a. Informant's Name/Relationship (7) Mark W. Perry	(son)	3605	ng Address (Stree	t and Number	or Rural R Woo	oute Number	er, City o	MD 21	163	
Baltimore, permit. Pages 1 ar Department of Hea Important: if Item			0a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State La	cemetery, cre ke Vie	osition (Name of matory or other pl EW_Mem	Park 1	Date . /13/			cation - City or kesvil		
Department of the contract of	DUC		21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or comp	W. Olm	Bu	2. Name and Add	Queen	Fune	ral	Home	e, PA	MdDroxi2ale7	84
Physicia / Medic / Medic / Medic / Medic / Examin physician and physician sud / Medic	eal ner	Cal Charmilei	shock, or heart failure. List only shock, or heart failure. List only shock, or heart failure. List only shock of the shoc	b. Due to (or as a consect.) Due to (or as a consect.) Due to (or as a consect.) Due to (or as a consect.)	ncer equence of):		ing, 3001 u3 90	arcioc y			,	Interval Betwee Onset and Deal	th
ds, P.O. Box 687 ires that the death certificate signed by the attending phys d be detached for use as the			FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	⊒Ectopic pregnan ⊒ Other (specify)	су				23d. Date of deli Month	very Day Year	r
I Records, P.O. The law requires that the stee has been signed by the same 2 should be detached.			art II. Other significant conditions o	ontributing to death bul not re	esulting in the t	underlying cause g	iven in Part I.			obacco u Yes 2		the cause of death	
Vital Record stoien: The law requir certificate has been si	Separate Sep								24a. Was autop perfo 1 ☐ Yes		prior to death?	lopsy findings avai ompletion of cause 2 No	ilable e of
of Vita Physicien: this certific		Ω]	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	☐ ER/Outpatie	3U DOA 0	thor		Check only o		C [] Oah (C		
On of ding Phy After this	F 10101	2	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inj	4 140/3	280	d. Describe		6 □Other (Spec y occurred	ny)	
Division Attention to the Hospital or Attention 24 hours after death To the Funeral Director:	n ka ili nei		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Special	home, farm, si	treet, factory, office	•	28f	Location (City or To			ral Route Number,	
the Hospital in 24 hours a the Funeral I	in the last			ysician: To the best of my k niner: On the basis of exami and manner stated.									
To the To the To the To the Common Co			29b. Signature and trie of certifier				nse number				te signed (Monti		
1						D139	99			Jan	11, 20	06	
9)	Μ	30. Name and adeless of person who lichael B. Pear	lman, MD 54	+00 01	-	Rd. #2	04 R	anda	llst	own, N	ID 21133	3
Reg	State gistra		31. Date filed (Month, Day, Year) JAN 1 1 200	32 Registrar's Sig	nature K	whi.							

			State of Maryland / Department of Health and M	-	_	
		•	For State of Waryland / Department of Fleath and Williams Certificate of Death		2006	00408
			Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
П	Physicia /Medic		Miriam Louise Pries	Jan 7	, 2006	1;55 P M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	h
			Lorien Nursing Home Mount Airy 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		Carroll	halasa /Stata as Faraira
P	Funeral Director		1 21 _ 22 _ 7665	8. Date of Birth (Month, Day, Y Sept 25	. 1912 N	hplace (State or Foreign juntry) Vew York
	D		Usual Residence of Decedent	sept 23	, 1/1/2 1	
	anylar show	5	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1)∑Xes 2 □ No
	the M	ecto	MD Carroll Mount Airy 10e. Street and Number 10f. Zip Code	100	. Citizen of What Co	
	3a or	Funeral Director	713 Midway Ave. 21771		ited Sta	
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe fr Yes, specify Cuban, Mexican, Puerto		14. Race - Ame Black, Whit	nican Indian,
36	or Ite	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No ☐ ☐ Yes . Give ☐ 1 ☐ Yes . 2 ☑ No . Specify:	r riouri, oto.)	Specify: Wh	
Ö	within 72 hours atter death with the Maryland ene. than "natural", or Items 23a or 28a-f show than "hedical Examinar must be notified at	ed by	3 X Widowed 4 □ Divorced Year or Dates:	16	b. Kind of Business	
715	in 72	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ng		Pub. Schs.
213	filed with Hygiene other tha	Com	4 Nursery & Kindergar			
nd	d tal	Be	17. Father's Name (First, Middle, Last) Ephraim Boehmer Kreson Velma V			
Maryland 21215-0036	should band Ment s markac umatic e	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			7in Codol
Ma	CI (0 = 6		Ellen Bonde (Daughter) 5501 Buffalo Rd. Mt			
ē,	s 1 and 3 if Health Item 27 other tra		20a. Method of Disposition 20b. Place of Disposition (Name of	-	c. Location - City or	
E	Page nent o int: If iry or		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) S. Carroll Crematory 1/	/9/2006	Winfiel	d, MD
Baltimore,	permit. Pages of Department of Himportant: If Ite any injury or of once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Fu	neral H	Ome	
_	g 0 = 9 9		1212 W. Old Liber	·tv Rd.	Winfiel	d, MD 2178
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final	respiratory arres	10.41	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	13 EFFSE	WITH	
Н	Examiner		Immediate Cause (Final disease or condition resulting in death) List only one cause on each line. List on each line. List on each line. List on each line. List on each line. List on each line. List on each line. List on each line. List on each line. List on each line. List on each line. List on each line. List on each line. List on each line. List on each line. List on each line. L			YRS
	D #	iner	if any leading to immediate UIII (0) as a consequence of):			
1	ecute and I-trans	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of):			YRS
760,	icate be executed physician and s the burial-transit	calE				
687	The law requires that the death certificate be executed the sas been signed by the attending physician and bage 2 should be detached for use as the burial-transit		g			
Вох	leath certificate attending phy I for use as the	M/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	
	e deal he att	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown		Month	Day Year
P.0	that the de led by the a		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	uires t signe	d by	a lavcoma Immobility syndrome	1 ☐ Yes		robably 4 Unknown
cor	w require been sign	Completed	pstermeric	24a. Was an	24b. Were at	utopsy findings available
Re	The lav	omp	os cofficios, s	autopsy performs		completion of cause of
Vital		BeC	25. Was case referred to medical 26. Place of Death	(Check only one)		, pa no
of V	Physiclan: this certific ral director,	2			ce 6 □Other (Spe	cify)
		lon:	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how	injury occurred	
Division	ten eatl tor: the	ficat	3 Suicide 6 Columniand 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre	et and Number or R	ural Route Number,
Ö	alor / s after il Dire	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town,	State)	
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier (Check only (Ch	and due to the cau	ise(s) and manner as	s stated.
	the H hin 24 the F nplete	Medical	one) and manner stated.		d. Date signed (Mont	
.	wit To	-				
,	m		30. Name and address of person who completed cause of death (Mom 23a) (Type, Print) All En Kerlly MD 801 Toll House Auc D-1, Free D- 31. Date filed (Month, Day, Year) 32. Registrar's Signature		/ /	20
	ر		AllEW Reilly MD 801 Toll House Ave D-1, FRED	erick	MD Z	1701
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,		
	Regist	rar	JAN 1 1 2006			

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
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			For State	State of M		epartment of F Certificate of		Mental Hygie	- 211116	nnung
· (4)	7 g		Registrar 1. Decedent's Name (First, Middle, Las	it)	`		Doutin	2. Date of Death	NO.	3. Time of Death
- 5	Physici		EXTRA F. PO	WELL				Month January 6	Day Year 2006	5:10 p ^M
	/Medic Examin		4a. Facility Name (If not institution, give)	4b. City, Town, o	r Location of De		4c. County of Deal	
		ja 1	STELLA MARIS HO	SPICE-TIM	IONIUM	TIMONIU	M		BALTIM	ORE CO
	Funeral		5. Social Security Number 6. S	9x 7. A	ge (In yrs. last birth	Months Days	If Under 24 H Hours Mi		9. Birt	thplace (State or Foreign
	Director		226-24-9542	ZAM ZLIF	82 Y	rs.	1.00.0	AUGUST 11	. 1923 V	IRĞINIA
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	danyi f sho	ō	MARYLAND Balt	imore		TE MARSH				1 □ Yes 2\taken No
	the 128a	Director	10e. Street and Number	Inorc	WIII	10f. Zip Code		10a.	Citizen of What Co	ountry?
	3a or	٥	347 LORELEY RD.				162		U.S.A.	,
	me 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of H			14. Race - Ame	
9	or Ite	F	1 Never Married 2 Married	Armed Forces 1 XYes 2 ☐ If Yes, Give				erto Hican, etc.)	Black, Whit	e, etc.
03	72 hours after death with the Maryland Instural, or Iteme 23a or 28a-f show dical Examinat rount be incliffed at	d by	3 Widowed 4 Divorced	Year or Dates:	44/46	1 ☐ Yes XX No	Specify:		Specify: B1	LACK
21215-0036	72 h "natu	Completed	15. Decedent's Ed (Specify only highest gra		7	Decedent's Usual Occup Give kind of work done	during most of w	rorking 16t	o. Kind of Business	/Industry
121	withir ne.	dm	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use retired CHIPPER	2)		STEEL	
d 2	filed Hygie ther int, it	e Co	4th grade 17. Father's Name (First, Middle, Last)			CHIPPER	18. Mother's N	ame (First, Middle, Mai		
anı	d be ental	8	ISSAC POWELL					E EDMOND	2011 (2011)	
Maryland	Shoul The Mark	ပ	19a, Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street		Rural Route Number, C	ity or Town, State.	Zip Code)
Ž	nd 2 ilth a 27 Is r trat		Odessa Powell/Wif	e	3	47 LORELY R	OAD. WH	ITE MARSH,	MARYLAND	21162
re,	s 1 a of Hea item othe	1 3	20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other place			c. Location - City or	
E	Page nent c nt: If rry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		,	ON FOREST		17-06 OW	IINGS MIL	LS, MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or iteme 23a or 28a-f show any injury or other traumatic event, it a Modical Examination is notified at ance.		21. Signatur of Funeral Service Licer	990 /	, 511111111			OMMUNITY FU		
<u> </u>	89559	, G	Marbara C	18		1206 W NOR	TH AVEN	UE		ME F.A.
180 E			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	lications that cause one cause on each	d the death. Do no line.	ot enter the mode of dyir	ng, such as card	ac or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a PANCRE	ATIC CANC	ER				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of):				
K		-	Sequentially list conditions,	b. Due to (or as	s a consequence of):				
V	uted J ansit	E E	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,				
×.	be executed icien and burial-transit	Examiner	resulting in death) Last	Due to (or as	s a consequence of):				
8760	cate be executed chysicien and the burial-transit	dical	(d						
9	ng ph ng ph s as th	Med	IF FEMALE:	<u> </u>						
Вох	death certific e attending p id for use as	lan/I	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnancy	,		23d. Date of de	livery Day Year
	the dea y the a	Physiclan/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a 9☐ Unknown	at time of death	5 Other (specify)			Worth	Day Tour
P.0		Phy	Part If. Other significant conditions of	ontributing to death	but not resulting in	the underlying cause give	ren in Part 1.	23e. Did tobac	co use contribute to	the cause of death?
ds,	w raquires thet been signed b should be deta	d by		In 100-		, ,		1 ☐ Yes	2 □No 3 □ Pr	robably 4 🛣 Unknown
COL	> 0 0	ete						24a. Was an	24h Were a	
Re	e la has	Completed			-			autopsy performed	d? death?	utopsy lindings available completion of cause of
tal	ilcian: Th certificate ector. pag	0	25. Was case relerred to medical				26 Place of C	1 ☐ Yes 2 X eath (Check only one)	No 1 Yes	2 □ No
>	Physician: r this certifica ral director.	To B	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 Inpat	ient 2 ER/Out	patient 3 DOA		Home 5 Residence	e 6 X Other (Spe	GIFV) HOSPICE
0	D 0 0		27. Manner of Death	28a. Date of Inj (Month, D	ury 28b. Ti	me of 28c. Injur	y at	28d. Describe how		- HODI TOU
<u>5</u>	anding sath. or: After he funer	atlc	1 XNatural 5 Pending 2 Accident Investigation	1			Yes 2 □ No			
Division of Vital Records,	br Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	288, Place of Ir	njury - At home, lari atc. <i>(Specify)</i>	n, street, lactory, office		28I. Location (Stree City or Town, S	t and Number or Ri tate)	ural Route Number,
	pitel ours a seef Dilled i		29a Certifier 11 Certifying Ph	unicing. To the bas	t of muckey and other	learn comment and the	data a si da			
	To the Hospitel or Attendin, within 24 hours after death. To the Funerel Director: After completely filled in by the fun	edical		niner: On the basis and manner s	of examination and	or investigation, in my o	pinion, death oc	ne, and due to the caus curred at the time, date	and place, and due	to the cause(s)
	To the within Fo the Somple	Me e	29b. Signature and title of certifier			29c. Licens	e number	29d.	Date signed (Mont	h, Day, Year)
			1				4277		11910	6
	,		30. Name and address of person who	completed cause of	death (Item 23a) (T	Type, Print)	1.1.6			
	0		DR. TARIQ MAHMO			ALLEY RD.	TIMONIU	M, MD 21093	}	
5	Sta		31. Date filed (Month, Day, Year)		trar's Signature	for we				
	Regist	ai	JAN 1 1 20	106	ye St.	South				

		T⊶ For State Registrar	State	of Marylar	nd / Depa <i>Cer</i>	irtment of F tificate of	lealth and <i>Death</i>	Mental Hy	gien o Reg. No.	006	00410
Physic /Medi		Decedent's Name (First, Middle Dale	, Last)	Poole				2. Date of Dea		2006 ^{Year}	3. Time of Death
Exami		4a. Facility Name (If not institution 1406 Baker Pla	_	-		4b. City, Town, o Freder	r Location of Dea	th		ounty of Death Frederic	ck
Funeral Director		5. Social Security Number 213-82-0583	6. Sex 1 □ M 2 □ F	7. Age (In yrs. 45	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)	Coù	place (State or Foreign ntry)
aryland show	'n	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					0d. Inside City Limits 1 ☑ Yes 2 ☐ No
with the M t or 28e-f	Director	MD Frede 10e. Street and Number	rick	Fr	ederic	10f. Zip Code			10g. Citize	en of What Cour	
I e, INIAI y IAI IU ZYZIOOOO s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene. Item 27 is marked other then "naturel", or Items 23a or 28e-1 show other treumatic event, the Medical Everth at marker retills of at	by Funerai	1406 BakerPlace 11. Marital Status 1 □ Never Married 2 ☒ Marr 3 □ Widowed 4 □ Divorced	12. Was De Armed F ied 1 1 1 1 1 1 1 1 1	cedent Ever in U Forces?		21702 Vas Decedent of H Yes, specify Cuba	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		Race - Americ Black, White,	etc.
within 72 houndless	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	s Education of grade completed		16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	during most of wo	orking	16b. Kind	Whit of Business/In	
yidilia CYR ould be filed with Mental Hygiene arked other the	Be	12 17. Father's Name (First, Middle,)ispatche	18. Mother's Na	ame (First, Middle,	Maiden Ŝi	ohia Cal	ole
Maryian d 2 should be th and Mental 27 Is marked o treumatic eve	To	Donald P. Poole 19a. Informant's Name/Relations Mrs. Thelma Sa	hip (Type, Print)	Matha	11		and Number or F	M. Thom	r, City or 1		Code)
Datiliore, Mappennit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 4 □ Donation 5 □ Other (S	3 □Removal from	n State 20b. I	Place of Dispo cemetery, cren	sition (Name of natory or other plac	ce)	ington M	20c. Loca	ation - City or To	
Dartillion permit. Pages Department of Importent: If it any injury or o		21. Signature of Fune al Service	11	en	22	© Cremat Name and Addre	ss of Facility Ke		Basi	sburg Nord Fur	neral Home
Physician		3a. Paul. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on	caused the deal each line.	th. Do not ente	er the mode of dyir	ng, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death Inutes
/Medical Examiner	_	resulting in death) Sequentially list conditions, if any, leading to immediate	b	o (or as a consec							
ficate be executed physician and the burial-transit	edicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	o (or as a consec							
The Colds, T.C. BOX of The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	utcome of pregn. birth 2 Feta gnant at time of c	aldeath 3□	Ectopic pregnancy	,		23	d. Date of delive Month	ery Day Year
law requires that as been signed be 2 should be deta	by	Part II. Other significant condition	ons contributing to	death but not res	sulting in the ur	nderlying cause giv	ren in Part I.		- 525		ne cause of death?
The lar	Completed							24a. Was autop perfor 1 □ Yes		prior to con death?	psy findings available mpletion of cause of 2 No
OI VICAL Physicien: r this certifical ral director, p	To Be	25. Was case referred to medica examiner? 1 X Yes 2 No	Hospital: 1		ER/Outpatien		er: 4 🗆 Nursing	eath (Check only on the second of the second	lence 6 [у)
lor Attending I or Attending I after death. Director: After I in by the funer	cation:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	not bo	e of Injury onth, Day Year) 2,2006	Unknow		yat k? Yes 2 X ∏No		ect h	anged s	
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	I Certificatio	4 Homicide determ	ined 289. Place	ding, etc. (Speci	At 1			1406 Bal	m, State) ker Pi	lace We	st, Apt 24 ervland
the Hos thin 24 ho the Fun mpletely	Medical	(Check only one) 2 Medical 29b. Signature and title of certifie	and ma	basis of examinationer stated.	ation and/or inv	restigation, in my o	pinion, death occ	eurred at the time, o	date and p	lace, and due to	the cause(s)
Q T		30. Name and address of person	olises	MD use of death (Item	DIME m 23a) (Type	D371		Į.		ry 3, 2	
0	210	Alan Rohrer, 31. Date filed (Month, Day, Year)	M.D., DMI		est Sev	enth Stre	eet, Fre	derick, N	Mary 1	and 217	01-4501
St Regist	ate trar	JAN 1 1	2006	2000 de	S. S.	rest !					

State of Maryland / Department of Health and Mental Hygiene, For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Theresa Margaret Proctor 8:20P /Medical January 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Clinton Convalescent Center Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2√2 F 220-32-6727 79 Director April 24, 1926 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Item 27 is marked other than "naturel", or itema 23a or 28a-1 show other treumatic event, the Mudical Examinar must be notified at 10d. Inside City Limits Prince George's Maryland Clinton Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9523 Temple Hill Road 20735 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 American Indian 1 ☐ Yes 21 No Specify: þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Agency Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) d 2 should be filed within in and Mental Hygiene.
7 ie marked other then " Elementary/Secondary (0·12) College (1-4or 5+) Administrative Ass't Environmental Probatio 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 1e marked any injury or other treumatic events. James Alton Proctor Elizabeth Helen Newman 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Welton Proctor, Sr. 9523 Temple Hill Road, Clinton, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan 11, Date 2006 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Cheltenham, Maryland Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee tach 400153 Alexandria Ferry Rd, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZHeimers **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Tes 2 No 3 Probably 4 ☐Unknown 24a. Was an autopsy perform 24b. Were autopsy lindings available prior to completion of cause of death? 2 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one examiner Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Day, Year) 035206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Tanner, MD 11701 Livingston Rd. Suite 101 Ft. Washington, Md. 31. Date liled (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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<u>=</u>	그 등 본 등		21. Signature of Funeral Service Licer	nsee	22.	Name and Address	fery 1/11/0 ss Facility BEH	5 EUDER	Al Horse	793
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DIVISION	in Sign	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	at home, farm, stre	et, factory, office	21	Bf. Location (Sti City or Town		or Rural Route Number,
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	6	111		30. Name and address of person wh	o completed cau	se of death (Ite	m 23a) (Ty e	Print)	355	En h		ang Company	VALUE OF	22300	7/20	, , , ,
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 6:30 \$ Physician KOSE ETHEL JANUARY 04 2006 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1timo mor If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 21,19 Birthplace (State or Foreign Mountry) 5. Social Security Number If Under 1 Year **Funeral** Min. Months Days Hours 1 ☐ M 2 X F Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f shov The Medical Examiner must be notified at Maryland 1 XYes 2 □ No Directo more 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ora Funeral Pages 1 and 2 should be tiled within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: þ Blac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) ertment of Health and Mental Hygiene. crtant: if Item 27 is marked other than njury or other traumatic event, Ital giver d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 seorae 19a. Informant's Na. Relationship (Type, Prin Tourally Et al.) 19b. Mailing Address (Street and Number or Rural Route Number, Se 263 Guil

20b. Place of Disposition (Name of cemetery, crematory or other place) 70Se Gull Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) arme 23a. Part. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

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any nju Approximate Interval Between Onset and Death Congestive than Physician teas. /Medical Examiner Bafehrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed union (or as a consequence of) Box 68760, phy IF FEMALE: USB 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ cate has been sig page 2 should t 3 ☐ Probably 4 Munknown Be Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 Inpatient Other: 1 Yes 2 No 3X DOA Certification: To 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Atter t 28d. Describe how injury occurred 1 XNatural 2 Accident 5 Pending death. I Director: A 1 TYes 2 TNo investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD, FACP D 51088 JANUARY 09,2006 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name an Than Poon Baltimore, MD 21202 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 JAN 1 1 Registrar

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<u>α</u>	quires that n signed b uld be deta		Part II. Other significant cond	itions contributi	ng to death-b	ut not resu	ulting in the u	Inderlying caus	given in	Part I.		obacco use		he cause of death?
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of Vit	Phys this ral di	n: To Be	25. Was case referred to med examiner? 1 Tyes 2 No 27. Magner of Death	Hospita	ı ∐ınpatı a. Date of İnji	ıry	FR/Outpatie		Other		th (Check only of lome 5 Resi	dence 6		(y)
Division	or Attsn ifter deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Co	stigation	(Month, Da	jury - At ho	Injury ome, farm, st	M reet, factory, of	1 🗆 Yes	2 🗆 No	28f. Location (City or To		lumber or Rura	al Route Number,
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18 M	Sta Regist	ate rar	30. Name and address of persons address of persons and address of persons a	bin 1				Print) 54	fol i	old (ourt K	20ad avylo	Rav	dailstown
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			For State Registrar	State of I	Maryland		artment of H		Mental Hy	giene Reg. No.	2008	5 00	416
	Physicia		1. Decedent's Name (First, Middle John L. Reims		r.				2. Date of Dea Month 01/05/0	ath Day	Yea		e of Death
	/Medic Examin	_	4a. Facility Name (If not institution,	give street and numb	er)		4b. City, Town, or	Location of Dea		4c.	County of De	eath	
₽.	Funeral Director		Cherry Lane Nur 5. Social Security Number 213-28-9834		Age (In yrs. las	st birthday) Yrs.	In Under 1 Year Months Days	If Under 24 Hr Hours Mir		h /, Year)	9. E	Georges Birthplace (Sta Country) aryland	te or Foreign
	ryland thow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside	e City Limits
	death with the Maryland ms 23c or 28e-f show	Director	MD Anne An	rundel	Jessi	up	10f. Zip Code			10g. Citiz	zen of What		es 2 No
	ath wi		7515 Montevided				20794			USA	Δ		
36	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "naturel", or flems 23s. or 28e-1 show event. The Medical Evantmer matter rullised at	by Funerai	11. Marital Status 1 □ Never Married 2 \overline{\chi} Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force ed 1 TYes 2 If Yes, Give		1	Mas Decedent of Hi f Yes, specify Cuba I□Yes 2XNo	ispanic Origin? (n, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)		4. Race - Ar Black, Wi Specify:	merican Indiar hite, etc. White	1,
Maryland 21215-0036	be filed within 72 hours after tal Hygiene. d other then "naturel", or Ite event, the Medical Examina	Completed	15. Decedent (Specify only highes	's Education		16a. Deced	lent's Usual Decupa kind of work done of DO NOT use retired	during most of w	rorking	16b. Kir	nd of Busines	ss/Industry	
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<u> </u>		မ	John L. Reimsr			401 44 11		Mattie					
<u> </u>	2 s is		19a. Informant's Name/Relationsh Jean Reimsnider				Montevid		Rural Route Numbe			, Zip Code)	
ଦ୍	is 1 and is 1 and item 27 other tr		20a. Method of Disposition	. / WILC	20b. Pla	ce of Disno	sition (Name of		Date		0794 cation - City	or Town, State)
E 0	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (Sp	3 □Removal from Sta	ate Meado	orial	patory or other plac Park, Inc	e) C O1 //	07/06	El les	i dan	1.4Th	
Baltimore,	permit. Pages Department of Importent: If i eny injury or once.		21. Signature of Funeral Service I		Treme	G 3	Name and Address ary L. Kauf	ss of Facility men Funer	al Home at lvd., Elk	Mead	ridge, wridge	Mem. Per	rk, INC.
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cau	ised the death.	Do not ente	er the mode of dyin	g, such as cardi	ac or respiratory ar	rest,	e, MD	Approxi	mate Between
1	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. End 5 Due to (or	FAGE as a conseque	Chre	nic Ost	ructive	Polmone	ry	Disea	Onset a	nd Death Year)
	cuted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	as a conseque	ince of):							
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rds, P.	w requires that been signed by should be deta	by	Part II. Dther significant conditio	ns contributing to deat	th but not result	ting in the ur	nderlying cause give	en in Part I.		es 2		to the cause Probably 4	of death?
I Records,	The law re ate has bee page 2 sho	Completed			-				24a. Was autop perfo 1 Yes		24b. Were prior t death	autopsy findin to completion o ? es 2 No	igs available of cause of
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hamitat					eath (Check only o		1		
	S 5	T.	1 ☐ Yes 2 🗹 No 27. Manger of Death	Hospital: 1 ☐ Inp		R/Outpatien		4 Le Nursing	Home 5 Resid			pecify)	
o	ding th. : After	tion	1 Natural 5 Pending 2 Accident investig	g (Month,	Day Year)	Injury	Worl	Yes 2 □ No	280. Describe i	iow injuty	occurred		
Division of	in Life	Certification:	3 Suicide 6 Could r 4 Homicide determi	not be 28e. Place of	f Injury - At hom , etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (5 City or Tow	Street and m, State)	Number or	Rural Route N	lum <i>ber</i> ,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical (29a. Certifier 1 Certifyin (Check only one)	g Physician: To the be Examiner: On the basi and manner	is of examinatio	ledge, death on and/or in	n occurred at the time vestigation, in my of	ne, date and place pinion, death oc	ce, and due to the courred at the time,	cause(s) date and	and manner place, and d	as stated. ue to the caus	60(S)
	To t To t	Σ	29b. Signature and title of certifier				29c. License			-		onth, Day, Yea	r)
			proble	Valor	MI)		D 3	1051		Jan	very	5, 2	006
0	10		30. Name and address of person of the dyes Sc	who completed cause	of death (Item 2	23а) (Туре,	Print) gon Rd,	Ellicot	t City	M	0 2	1042	
8	Sta Registi	_	31. Date filed (Month, Day, Year) JAN 1 1	2006 22 A	Jistrar's Signatu	A Part	and the		, ,				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) AMend Item #20a-c&22 Per FH C851 1/20/08/ificate of Death
1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Karen Shipp January 1, 2006 9:56 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Montgomery Village Montgomery ar If Under 24 Hrs. 8. Date of Birth 9. Birtholace Montgomery Village Nursing Center If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Deys Hours Months 1 □ M 2 🖫 F Jan 11, 1946 Virginia Director 220-48-9586 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mentel Hygiene.

ant: If item 27 is marked other than "natural; or items 23s or 28s-f ahow ury or other traumstic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Montgomery Village MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20886 IISA 19301 Watkins Mills Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 M Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 payroll clerk healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Shipp June Hawes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kim Delph/daughter 11410 Tulip Poplar Terrace Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition 1 ☐ Burial 2 remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Cherrify) in State Department of important: if it any injury or o 1/14/06 Alexandria , Virginia Metropolitian Crematory 22 Name and Address of Facility Muriel H., BarberFuneral Hone 21. Signature of Funeral Servi Ronald Director 21201 P.O.Box5038 Baltimore, MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Laytonsville,Md Approximate 1882 Interval Betwee 882 Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical VENTRICOLAR FIBRILLATION Examiner Due to (or as a consequence of): Examine STAGE RECAL DISEASE buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of)

funeral director,

the ettending physician end hed for use as the buriel-tran ste hes been signed by the epage 2 should be deteched \$ Completed Attending Physician: Be Certification: To this death. Director or A after

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 3 Probably 4 Unknown 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 25410 1 ☐ Yes 2 DkNo 1L Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 □ No 2 Accident investigation 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

H0051280

29d. Date signed (Month, Day, Yeer)

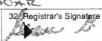
1-2-2000

State Registra

Medical

ANCOHICANA 31. Date filed (Month, Day, Year) 2006 JAN 1 1

29b. Signature and title of detifier



30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)



To the Hospital within 24 hours a To the Funeral C completely filled Hospital 624 hours a

TOURS TO BE A STATE OF THE STAT				For State of Maryland / State Registrar	Department of Health and M Certificate of Death	lental Hygien Reg. N	-000 00710
Examination Exami		DI		1. Decedent's Name (First, Middle, Last)			av Vear
Explicit Control County Services and Fundamental Control County Services and County Se				Kuben Simpson			
Usual flace/colored of Discontine Country (1982) and the Country (19		Examin Funeral		Good Samaritan Hospita, 5. Social Security Number 6. Sex, 7. Age the yrs. last by	Baltimure Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign
The part of the pa		D	9			01.51711	
The part of the pa		Marylan a-f show	tor	10a. State 10b. County 10c. City, Tov	m or Location Baltémore		10d. Inside City Limits 1 Yes 2 □ No
The part of the pa		h with the 23a or 28 st be not	al Dire	10e. Street and Number 3808 Cottage Ave	10f. Zip Code 2/2/5	10g. C	Citizen of What Country?
The part of the pa	036	urs after deat al', or Items ; Examinat mu	2	Armed Forceş? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes (8/9)	If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, White, etc.
The part of the pa	215-0	ithin 72 ho ne. nan "natur Medical	npleted	(Specify only highest grade completed)	(Give kind of work done during most of work Jife. DO NOT use retired)	ing	
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Provider Shopk of heart fature. List only one cause on each line. Introduce Cause (Final Introduce Cause Cause (Final Introduce Cause Cause (Final Introduce Cause (Final Introduce Cause (Final Introduce Cause Cause (Final Introduce Cause Cause (Final Introduce Cause Cause (Final Introduce Cause Ca	Ba	permit Depar Impor eny in		21. Signatury Funeral Servit License	(Gares P. March f	red HILTON	are buto and 2, 2, 229
Due to (or as a consequence of): Commonwealth of the conditions of the control				23a. Part 1. Ener the disease, or complications that caused the death. Do shopk, or heart failure. List only one cause on each line.			Approximate Interval Between
Sequentially list conditions Cause Disease of Injury Cause Disease D	E			disease or condition	you failure		Onset and Death
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The second process of the second program of	760,	sicien al burial-l		resulting in death) Last Due to (or as a consequence	of):		
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The state of the s	rds	quires n sigr uld be		CHE, Demention, GIble	erd, CVA,	1 🗆 Yes	2 No 3 Probably 4 Unknown
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Deeth 1 Page	Seco	2 5 8	mplet	M7W	, – ,	autopsy	24b. Were autopsy findings available prior to completion of cause of death?
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrar's Signature	ta	nn: Th		25. Was case referred to medical	26 Place of Deat		No 1 ☐ Yes 2 ☐ No
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrar's Signature	ſΝ	ysicionis cer direct	0 8	examiner?	Other		6 ☐Other (Specify)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrar's Signature	o uo	nding Ph th.: After the funeral		1 ☐Natural 5 ☐ Pending (Month, Day Year)		28d. Describe how inj	jury occurred
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Viol. R. Hegde, MD, 660 LOCH Royan Blvd, Baltimore, MD 31239 31. Date filled (Month, Day, Yeal) 32. Registrar's Signature	Divis	of or Atter after dea Director	ertifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, 1	arm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Viol. R. Hegde, MD, 660 LOCH Royan Blvd, Baltimore, MD 31239 31. Date filled (Month, Day, Yeal) 32. Registrar's Signature	^	Hospite 24 hours Funerel stely filler		(Check only 2 Medical Examiner: On the basis of examination a	ge, death occurred at the time, date and place, nd/or investigation, in my opinion, death occur	and due to the causer red at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Viol. R. Hegde, MD, 660 LOCH Royan Blvd, Baltimore, MD 31239 31. Date filled (Month, Day, Yeal) 32. Registrar's Signature	う	To the within Fo the comple	Me		29c. License number	29d. C	Date signed (Month, Day, Year)
Via: R. Heade, MD, 5601 LOCH ROVEN Blue, Buttimore, MD 31239		. 250		Milherale, Mr	D 1-0539		1-9-06
31. Dite filed (Month, Day, Yeal) 32. Registrar's Signature				30. Name and address if person who completed cause of death (Item 23a	(Type, Print)	Baltimon	c, MT 21239
Registrar JAN 1 1 2006					Links		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 9 per fh 8851 1-13-06 vt
State of Maryland / Department of Health and Mental Hygiene 00419 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year

1 - For State Registrer

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 Ph // Ex

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

lical	Arien S.	Shiffett Janu	ary 5,2006 1630PM M
iner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Prince George's Hospital	Cheverly	Prince George's
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	/ If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month)	Birth 9. Birthplace (State or Foreign Country)
	223-14-0716	Mar	
	10a. State 10b. County 10c. City, Town or to	ocation	10d. Inside City Limits
	Maryland Prince George's Up	per Marlboro	1 ☐ Yes 2X No
	10e. Street and Number 14720 Crescent Drive	10f. Zip Code 20772	10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give △ Year or Dates:	Was Decedeni of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.	14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Business/Industry
2000	Elementary/Secondary (0·12) College (1-4or 5+)	DO NOT use retired)	
	6th For	eman	State Highway Admin.
	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mic	ddle, Maiden Sumame)
	Clarence Shiflett	Lena Car	ve
	19a. Informant's Name/Relationship (Type, Print) 19b. Ma.	ling Address (Street and Number or Rural Route Nu	umber, City or Town, State, Zip Code)
	Linda Kaplan (Daughter) 147	20 Crescent Dr. Upper Ma	arlboro, MD 20772
	20a. Method of Disposition 20b. Place of Dis	position (Name of Date ematory or other place)	20c. Location - City or Town, State
	1427 Bullat 2 Clemation 3 Chemoval notificate _		
		Cemetery Jan 10, 2006 22. Name and Address of Facility Lee Fune	Fort Valley, Virginia
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	110000		Road Clinton, MD 20735
	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respirato	Interval Between
	Immediate Cause (Final disease or condition	ANUAL BLE	Onset and Death
	resulting in death) Due to (or as a consequence of):		
	Immediate Cause (Final disease or condition resulting in death) Dua to (or as a consequence of): Dua to (or as a consequence of):	ONLA	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
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5	d		
nysician/Medical	IF FEMALE: 230 If was outcome of programmy		
3		☐Ectopic pregnancy	23d. Date of delivery Month Day Year
S	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5	Other (specify)	- Day
	9 Unknown		
2	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. D	Did tobacco use contribute to the cause of death?
		1	Yes 2 No 3 Probably 4 Unknown
		24a. V	Was an 24b. Were autopsy findings available
completed			utopsy prior to completion of cause of death?
_		1 T Ye	
0	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check of	
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5	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury 27. Manth, Day Year) Injury 28b. Time	Work?	ibe how injury occurred
	2 Accident investigation	M 1 Yes 2 No	
	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		on (Street and Number or Rural Route Number, Town, State)
Celulication			
	29a. Certifier 1X Certifying Physicien: To the best of my knowledge, de	ath occurred at the time, date and place, and due to	the cause(s) and manner as stated.
ealcai	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the ti	me, date and place, and due to the cause(s)
Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		70 058182	1-5-2006 14 MD 20785
	CO No and district the control of th	Period)	, ,
	30. Name and address of person who completed cause of death (Item 23a) (Typ	DITAL NO PHOVER	111 mn 21185
	31 Date filed (Month Day Year) 22 Positions Cinnature	PIITIL EX LILIEN	9 1110 00 100
ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature		

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Year SIGAL GLORIA 01:25 AM 2006 JANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OPKINS MORE L If Under 24 Hrs. 144 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 M 2 X F Yrs. Director 8/21/55 5.0 213-68-8732 Maryland Usual Residence of Decedent with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Md n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 21224 250 S. Eaton Street USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1. Never Married 2 Married 1 ☐ Yes 2 MNo ff Yes, Give Year or Dates: ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced "naturel", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Disabled none other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be s 1 end 2 should be fi Heelth and Mental H tem 27 is marked otl 2 Jane McCollam John Sigai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicholas Bordner / Son 46 Nakota Ct. Baltimore, Md. 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 nent of h 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If any njury or njury or Bayview Crematory 1/11/06 Baltimore, Md. 21. Signature of Funeral Service Licenses Kaczorowski Funeral Home P.A. 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician ENDOCARDITIS 4 weeks /Medical Due to (or as a consequence of): Examiner BACTEREMIA Sequentiafly fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last week Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed HEPATIC FAILURE weeks Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sign 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No 1XYes 2□No Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be funeral director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 ★ Inpatient 2 ER/Outpatient 3□ DOA Pis 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Alter Injury 1 Naturat 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident efter death the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeret 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and titte of certifier 29c. License number 29d. Date signed (Month, Day, Year) Thong MEDICAL DOCTOR · Ungeline RES-000 7, 2006 January 30. Name and address of person who completed cause of death (Hem. 23a) (Type, Print)

Angeline Chong, 600 North Wolfe Street, Baltimore, Maryland 21287 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For Stata Registrar	State of Maryl	and / Department of Health Certificate of Deati	h	giene 006	00422
	Physici		1. Decedent's Name (First, Middle, L. James Edw		Vois	2. Date of Dea Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gi	ive street and number)	4b. City, Town, or Location	n of Death	4c. County of Death	11.5
	Funeral Director		5. Social Security Number 6.			er 24 Hrs. 8. Date of Birth	9. Birth	nplace (State or Foreign intry)
	p		Usual Residence of Decedent 10a. State 10b. County	100	Cily, Town or Location	10		10d. Inside City Limits
	with the Mar a or 28e-f s	Funeral Director	MD Bal+	imore 1	Candallstown 10f. Zip Code		10g. Citizen of What Cqu	1 ☐ Yes 2 No untry?
	death will ms 23a o	eral D	3704 Offutt	12. Was Decedent Ever	in U.S. 13. Was Decedent of Hispanic Clif Yes, specify Cuban, Mexic	Origin? (Specify Yes or No-	USA 14. Race - Ameri	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Marylen f Heelth and Mental Hyglene. Item 27 is marked other than "naturati, or items 23a or 28e-f show other traumatic svent, it a Madical Exemiter must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	If Yes, specify Cuban, Mexic		Specify: Black	i, etc.
215-0	hin 72 ho s. in "natur Medical	Completed	15. Decedent's l (Specify only highest g	Education irade completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during me	ost of working	16b. Kind of Business/Ir	ndustry
2	2 should be filed withir and Mental Hygiene. is marked other than aumatic svent, tre M	Be Com	17. Father's Name (First, Middle Las		Supervisor 18. Moi	ther's Name (First, Middle,	Maiden Sumame	ing Diary
ryland	hould be d Mental marked matic sv	To B	Herman Sy	Kes Print	19b. Mailing Address Street and Nan	200	gess Jity or Town, State, Zi	in Code)
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altimore	Page ent o nt: if ry or		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Content of the C	☐Removal from State	b. Place of Disposition (Name of cometery, crematory of other place) arden of taith	1-13-06	Balton - City or T	rown, State
Balti	permit. Pag Department Importent: any injury once.		21. Sign ture of Funeral Service Dict		Name and Address of Far 87287 her tu	Rd. Randa	neral Sellstown, o	
			23a. Part1. Enter the disease, or con shock, or heart failure. List onl Immediate Cause (Final	ly one cause on each line.	death. Do not enter the mode of dying, she	as cardiac or respiratory are		Approximate Interval Between Onset and Death
7	/Medical Examiner		disease or condition resulting in death)	a. Due to or as a con	1 . 1 1 1	1.		unknown
			Sequentially list conditions, if any, leading to immediate	b. Supra u	ventricular tack	nycardia		unthown
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	/Medic Examin Funeral Director	_	4a. Facility Name (If not institution, give 524 N 65. Social Security Number 6. Se 105-22-3125 10 Usual Residence of Decedent	arles St. 12	il E		8. Date of Birth	4c. dounty of Death	A place (State or Foreign intry)
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	To the within 2 To the complet	Me	29b. Signature and title of gertifier	00404		c. License number		d. Date signed (Month	n. Day, Year)
,			30. Name and address of person who	completed cause of death (Item 2:	3a) (Type, Print)) 00Px 101	DESAL	M. D	
	C.	ate	30 St. Hau # 100 Ba 31. Date filed (Month, pay, Year)	Street MD THIMOSE MD	21202				
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TERESA SMITH 06-0099 Unpend Items: 23a part I III,27,28a,b,c,d,e,f,per MEO 1/21/06 G-851
State of Maryland / Department of Health and Mental Hygiene RKD 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** eresa JANUARY 9:04A. 2006 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3604 BOWERS AVE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 214-88-3885 Usual Residence of Decedent 1 ☐ M 200 F Yrs Director with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location and Mental Hygiene. Is marked other then "natural" or Items 23s or 28s-f show raumatic event, the Medical Examinar must be notified at 1 ¥Yes 2 No Directo Maryland 10e. Street and Number 10f. Zip Code Apt. 10g. Citizen of What Country? 3604 filed within 72 hours after deeth Funeral 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary Secondary (0-12) College (1-4or 5+) ousek 0 epina permit. Pages 1 and 2 should be filed w Dependrent of Heelth and Mental Hygies Important: If Item 27 is marked other til eny injury or other traumatic event, Ins. ODGE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Drraine 19a. Informant's Name/Relationship (Type, Print) (Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or 20b. Place of Disposition (Name of cemetery, crematory or other place) Son leight 20a. Method of Disposition Date 20c. Location 1 Burial 2 □ Cremation 3 Removal from State 2006 4 ☐ Donation 5 ☐ Other (Specify) emetery 21. Signature of Funeral Service/Licensee 22. Name and Address - Facility Funeral H ve. Balto Joseph L. Russ Fund 2722 W. Worth Ave. 23a. Part Enter the 14, ase, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Neck injury Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical as ettending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4☐ Pregnant at time of death signed by the e 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic renal disease 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of each?

Yes 2 \sum No page 2 certificete 1 Yes of Vital 2 □ No 25. Was case referred to medical examiner?
1 \(\times \) Yes 2 \(\times \) No After this certific funeral director. Be 26. Place of Death (Check only one | Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ② Other (Specify) SCENE ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury Pin 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 □Natural 2 △ Accident 5 Pending investigation death. 1/04/06 Unknown ™ 1 ☐ Yes 2 ☑ No Subject fell down steps within 24 hours after deati To the Funsral Director: completely filled in by the 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
HOME 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3804 BOWERS AVE. 4 T Homicide Baltimore, Md. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) though O.C.M.E. <u>JANUARY 5, 2006</u> nd address of person who completed cause of death (Item 23a) (Type, Print) Ron 10c temy 111 PENN STREET BALTIMORE MARYLAND 21201 31. Date filed (Month, Day, Year)

State Registrar

IAN 4 1 2000

32. Registrar's Signature

				1 - State Registrar	State of	Marylan		rtment of H				giene2 0	06	00425
		Ž.a	ğ ,	Decedent's Name (First, Middle, Last	st)						2. Date of De	ath		3. Time of Death
		Physici /Medio		Raymond	Victor	Sim	ms				January	y 10, 20	Year 106	2:40 A M
		Examir		4a. Facility Name (If not institution, give	street and numb	ber)		4b. City, Town, or	r Location	of Death		4c. County		
				Gilchrist Cente				Tows					timo	
	В	Funeral Director		5. Social Security Number 6. S 217-46-1714	ex 7 X M 2□ F	. Age (In yrs. I 58	ast birthday) Yrs.	Months Days	Hours	Min.	8. Date of Bird (Month, Da Dec. 2:	v. Year)	9. Birth Cou Ma	place (State or Foreign ntry) rvland
		D >		Usual Residence of Decedent 10a, State 10b, County		10- 07-	7							
		anyla ehov	5				r, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 No
		the N	ect	Maryland Baltimor	'e		Phoeni	X 10f. Zip Code				10g. Citizen of V	1/5 - A C	
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AN		ours after death with the Marylan ral', or items 23a or 28a-1 ehow Exaculner court be notified at	by Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U.	S. 13. V	Vas Decedent of H Yes, specify Cuba		igin? (Spe	ecify Yes or No			ican Indian,
	9	or ite	Ē	1 ☐ Never Married 2 🕅 Married	Armed Ford	X No	1				Rican, etc.)		k, White	, etc.
2	933	ural',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dat	es:		Yes 2X No	Specify			Specify	. Wh	ite
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)	d 2	filled Hygir other	Be Co	17. Father's Name (First, Middle, Last)			Jupe	rincendal		er's Name	e (First, Middle,	Maiden Suman		rytanu
Ex.	ryland	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other then "natural", or items 23e or 28e-f show unatic event, ite Medical Examinational Legisland	To B	Thomas A.	Simms,	Jr.			Ma	ry	Finch			
0	Mar	01 00 30 50	1	19a. Informant's Name/Relationship (• • • • • • • • • • • • • • • • • • • •			g Address (Street						p Code)
0		1 and fealt		Nancy R. Simms 20a Method of Disposition	Wife_	20h P		Robcaste			Phoenix	, Maryla 20c. Location -		21131
0	Baltimore,			1 □ Burial 2 X Cremation 3 □	Removal from St	ialo [sition (Name of eatory or other place						
10)	ij	그는 근 글	1	21. Signal to Fun of Servic Licer	•	Hil		ervice Co		da a		Towson		
1	Ba	Depariment Department of the suny in the sunce.		Valla lings				050 York		Ruc	ck Towso owson, N	on Funer Maryland	al H 21	ome, Inc. 204
-				23a. Part 1. Enter the disease, or com- shock, or heart failure. List only	plications that car one cause on ear	used the death ch line.	. Do not ente	er the mode of dyin	ig, such as	cardiac o	or respiratory as	rrest,		Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	а.	LU	na	Ancei	R					Onset and Death
D		/Medical Examiner		resulting in death)	Due to (o	r as a consequ	uence of):							
6	*		-	Sequentially list conditions,	b. — Oue to (o	r as a consequ	savina vili:							
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3	O,	siclen and burial-transit		resulting in death) Last	Due to (o	r as a consequ	ence of):							
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	Вох	leath certifii attending p	lan/	23b. Was decedent pregnant in the past 12 months?		th 2 Fetal	death 3	Ectopic pregnancy	,			23d. Da	e of deliv	ery Day Year
4	0	the de	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnai 9☐ Unknov	nt at time ot de vn	eath 5	Other (specify)				1410		Day Teal
1 2	۹.	that the de ed by the detached	/ Ph	Part II. Other significant conditions of	ontributing to dea	ith but not resu	ulting in the un	derlying cause give	en in Part	t.	23e. Did to	obacco use cont	ribute to	the cause of death?
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S	ပ္ ၁	law rees bee	Completed								24a. Was		Nere aut	opsy findings available
- 5			E O			,					autop perfo 1 Yes	rmed?	death?	ompletion of cause of
- ^	Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?						e of Death	Check only o			
3	of \	Physic r this c ral dire	၉	1 ☐ Yes 2 反 No	Hospital: 1 🗆 Inj		ER/Outpatient		4 🗀 14			dence 6 Oth		ty) (xx) ce
5		ffe f	lon	27. Manner of Death 1 Natural 5 □ Pending		Day Year)	28b. Time of Injury	28c. Injun Worl			28d. Describe I	now injury occurr	ed	3.7 V
2	ision	Attending ir death. ector: After by the fune	lcat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be		of Injury - At ho	me farm stre	et, factory, office	Yes 2□	-	28f Location /	Street and Numb	ar or Que	al Route Number.
7	? <u>≧</u>	al or At s after o il Direct od in by	Certification;	4 Homicide determined	building	g, etc. (Specify	<i>(</i>)	set, factory, office			City or Tov	vn, State)	er or hur	ar noute warnber,
2		To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifying Ph (Check only one)	ysician: To the b niner: On the bas and manne	sis of examinal	wledge, death tion and/or inv	occurred at the tin estigation, in my o	ne, date ai pinion, dea	nd place, a	and due to the ed at the time,	cause(s) and ma date and place,	inner as a	stated. to the cause(s)
		To the Hos within 24 hd To the Fun completely i	Me	29b. Signalure and title of certifier	a	2		29c. License	e number			29d. Date signe	d (Month,	Day, Year)
		, ,, ,		M Anthu	us Rul	Len	uno	100	500	05		JANIU.	916	1,2006
		20		30. Name and address of person who	completed cause	of death (Item	23a) (Type, I	Print)	(1)					
				31. Date filed (Month, Day, Year)	5- BIM	V 670	11 N-	Chales	Jt.	La	110.60	nd 21	20,	X
		Sta Registr			2006	gistrar's Signa	G A	ale						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year Physician 2006 January 9, Roger B. Sterk, Jr. 1:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospice of Baltimore Gilchrist Center Baltimore Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 27, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 M 2 □ F 216-17-3073 30 Canada Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits r than "natural", or Itama 23s or 28s-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5105 Castlestone Drive 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Regional Sales Manager Wireless Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ages 1 and 2 should be fill and Mental H. It item 27 is marked oth Be Roger B. Sterk, Sr. Dianne M. Maultsby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Ardoon Road; Lutherville, MD 21093 Roger B. Sterk, Sr. / father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ☐ ☐ Other (Specify) Dulaney Valley Mem Gardens: 1/13/06 Timonium, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications by a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or s a consequadce of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): attending physicien a for use es the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 TUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, o Division of Vital

the Hospital or Attending hours after within 24 hours a To the Funerei D

15

(Check only one)

Medical

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Al-Charles St. Balto Md Z1208

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

				partment of Health and N ertificate of Death	Mental Hygie Reg	ZUUb	00427
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
. III	Physici /Medic		Ruth Katherine Streeks		January	6, 2006 Year	10:55A M
X	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	T	4c. County of Deat	
	. 6		Gilchrist Center	Towson av) If Under 1 Year If Under 24 Hrs.	10.7	Baltim	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y)	9. Birt 1013 Novi	hplace (State or Foreign
			Usual Residence of Decedent		August 29,	1312 NGM	Jérsey
	how		10a. State 10b. County 10c. City, Town o	Location			10d. Inside City Limits
	ith the Marylan or 28a-f show	cto	Maryland Baltimore Towso	1			1 ☐ Yes 2X No
	vith th	Director	10e. Street and Number	10f. Zip Code 21204	10g	. Citizen of What Co	untry?
	s 23s	erai	1 Smeton Place Unit 405	1		USA	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelih and Mental Hygiene. If filem 27 is marked other than "natural", or items 23a or 28a-f show if filem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Marical Exam. ar must be exittle 1 at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XXWidowed 4 Divorced	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify: 	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
5-0036	2 hou		15. Decedent's Education 16a. De	cedent's Usual Occupation	16	b. Kind of Business/	
2121	within 7 ene. than "n	Completed	(Specify only highest grade completed) (G	ive kind of work done during most of work e. DO NOT use retired)	ang		•
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7	should nd Men i marke	은	Gilbert Bushby 19a. Informant's Name/Relationship (Type, Print) 19b. M	Genevi		worth	
Ma	d 2 sl th an th an t7 is r traur			ailing Address (<i>Street and N</i> um <i>ber or Rui</i> Meton Place Unit 40		ity or Town, State, 2 , Marylan	
ව්	ges 1 and 2 t of Heelth If item 27 or other tr		20a Method of Disposition 20b Place of Di	enosition (Name of		c. Location - City or	
ê	Pages nent of int: If its iry or o		TA Duties 2 Commented of State	n Cemetery 1/10			Maryland
Baltimore,	교론활출 .		21. Signature of Funeral Service Uconsee	22. Name and Address of Facility	/2000 N	Oddiawii	21204
m	Deperment of the population of		Michael duck In	Ruck Towson Funeral Home	e, Inc. 1050	York Road *	111
			23a. Part 1. Enter the disea e r complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician	W.	Immediate Cause (Final disease or condition End Stra	e dementia		1	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of)				1110111115
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4	red nslt	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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Вох	The law requires that the death certifi sie has been signed by the attending l page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of deli	very
). E	the at	sici	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month	Day Year
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ds,	signed det	l by	Part II. Other significant conditions contributing to death but not resulting in the	at disense,	23e. Did tobac	co use contribute to 2 XNo 3 ☐ Pro	the cause of death?
Records,	w requir been si should	Completed		n i di de nacij		/\	
Rec	he lay	du	Anemia		24a. Was an autopsy performer	prior to d	topsy findings available completion of cause of
ā	rsician: The law s certificete has t lirector, page 2 s	မ င်	25. Was case referred to medical		1 ☐ Yes 2 🔀	(No 1 ☐ Yes	2 No
of Vital	ysicia s cert direct	0 8	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Other	h Check only one	e 6 X Other (Spec	the blacking
ō	ig Ph ter th	i.i	27. Manner of Death 28a. Date of Injury 28b. Tim	of 28c. Injury at	28d. Describe how		(11y) HOSPICE
Division	endir sath. or: Af he fur	Certification:	2 Accident investigation	M 1 Yes 2 No			
Ξ̈́	or Att	rtiff	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	pitai ours a erei C		20a Contine 150 Contine Oh	4			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifice completely filled in by the funeral director; g	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, d (Check only one) Medical Examiner: On the basis of examination and/o and manner stated.	earn occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To th within Fo the	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Monti	, Day, Year)
			M. Hythony Kiley . mo	D25205	J	MURY	6,2006
	8		30. Name and address of person who impleted cause of ath (Item 23a) (Ty. A. R. Ley GBMC 670)	N. Charles St.	Balto. 11	nd Z1 Z	26
is.	Sta Registr			pole			

Amend item#195, Perri, Cont, in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State	State of M	aryland / Dep	artment of F	lealth and	Mental Hy		006	00428
	_		Registrar 1. Decedent's Name (First, Middle, Las	t)		Tuncate of	Dealli	2. Date of D	Reg. No.		3. Time of Death
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	/Medio Examir		4a. Facility Name (If not institution, give			4b. City, Town, or			4c. Co	unty of Death	,
			HOWARD CNNTY	GEN its	SPITAL	Coli	MAIA		1+	SWAN	2
	Funeral		5. Social Security Number 6. Se	9x 7. A	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		rth ay, Year)	9. Birth	place (State or Foreign
	Director		216-09-2081 1	X	85 Yrs.			JUL.20	,1920		MD
	/land		10a. State 10b. County		10c. City, Town or Le	ocation		··			10d. Inside City Limits
	Man Med sh	to	MD HOW	IARD	COLU	MBIA					1 □Yes 2 🙀 No
	or 284	Director	10e. Street and Number	-	-	10f. Zip Code			10g. Citizen	of What Cou	ntry?
	23a uset b	ral	5339 CHASE LIONS	WAY			21044				USA
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? an, Mexican, Pue	(Specify Yes or N erto Rican, etc.)	0- 14.	Race - Ameri Black, White,	
36	72 hours after death with the Maryland Instural', or Itema 23a or 28a-1 show Iteal Examiner must be motified at	by F	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:	No ARMY	1 ☐ Yes 2 💢 No	Specify:		Sp	ecify:	WHITE
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215	within 72 ene. than "n	Completed	(Specify only highest gra-	de completed) College (1-4or	(Give	kind of work done of DO NOT use retired	during most of w	rorking			,
2	filed withi Hygiene. other than ent, the M	Son	Elementary/Secondary (1-12)	5010 g 0 (1 401	CAB	DRIVER			LIVER	Υ	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, Last)					ame (First, Middle	e, Maiden Sui	mame)	
<u>yla</u>	should be nd Mental marked o	2	JACOB		SEID		GOLD				SAPPONICK
Nar	12 sho		19a. Informant's Name/Relationship (7	* * * * * * * * * * * * * * * * * * * *	19b. Maili	ng Address (Street	ons	Rural Route Numl	ber, City or To	wn, State, Zij	Code)
	1 and Health tem 27 other tr		JERRY SEIDMAN / 20a. Method of Disposition	2011	20b. Place of Dispo	CHASE LI	UNSWAY	- CULUMB		21044 ion - City or T	oum State
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		1 X Burial 2 ☐ Cremation 3 ☐		cemetery, cre	matory`or other plac	1				
臣	artme artme ortant injury		' 4 □ Donation 5 □ Other (Specify 21. Signature of F eral Service Licen		FORBAND		1	10/2006		EDALE,	
Ba	permi Depa Impo any i				- Q	2. Name and Addres	EDCTURN 2	OF FEATM	SUN &	BKUS.,	INU.
			23a. Part1. Enter the disease, or conditions shock, or heart fallure. List only	lications that cause						ILLL	Approximate
B	Priysician		Immediate Cause (Final		DIOMTOP						Interval Between Onset and Death
	/Medical		disease or condition resulting in death	Due to (or as	s a consequence of)-					-	
l.	Examiner		Sequentially list conditions,	b COROR	VAR7 ARI	EN) B	NEASE				
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	and and trans	Examiner	that initiated events resulting in death) Last		a consequence of):	——————————————————————————————————————					
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387	icate be executed physician and s the burial-transit	edicai		d. D/ L/1	C/2/1C)						
Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy				234	. Date of deliv	an/
ĕ	death a atter	Physician/M	in the past 12 months?	4☐Pregnant a		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	,		250	Month	Day Year
<u>о</u> .	t the cache	hys	9 Unknown	9□ Unknown							
S,	res that the de signed by the a be detached to	by P	Part II. Other significant conditions co		but not resulting in the u	Inderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
ırd	w require been sig should b	l pa	HONTIC STEW					1 🗆	Yes 2□N	lo 3 ☐ Prol	pably 4 Unknown
of Vital Records,	law re as be 2 sho	Completed	1-1700 71+71	,				24a. Wa auto	s an 2	4b. Were auto	ppsy findings available
<u>m</u>	The ate h page	Com	MONOCLENAL	GAMM	PATHY			perf	ormed? 2 Ø No	death?	
/ita	yeician: The law is certificate has t director, page 2 s	Be (25. Was case referred to medical					eath (Check only		740	
)t	> 0 0	은	1 ☐ Yes 2 Ø No		ient 2 ER/Outpatie	nt 3 DOA Oth	er: 4 ☐ Nursing	Home 5□Res			5/)
N C	ffer ne	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. Time o ay Year) Injury	Wor		28d. Describe	how injury or	curred	
Division	death death stor: / the	cat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Ir	njury - At home, farm, st		Yes 2 □ No	29f Location	/Street and N	umbor or Our	al Route Number.
<u>></u>	after Direct In by	ertif	4 ☐ Homicide determined	building, e	tc. (Specify)	ieer, ractory, onice		City or To	wn, State)	umber or Aure	ar House Mumber,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 12 Certifying Ph	ysician: To the bes	t of my knowledge, deat	h occurred at the time	ne, date and pla	ce, and due to the	cause(s) and	d manner as s	tated.
	1 24 Full	edical	(Check only 2 Medical Exam	iner: On the basis and manner s	of examination and/or in	vestigation, in my o	pinion, death oc	curred at the time	, date and pla	ice, and due t	o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number			gned (Month,	
	0			ATTEND	ING	D005	6948		JAN	3 1	1006
1			30. Name and address of person who		death (Item 23a) (Type,	Print)	- 0	- 04:	1	-0.5	- 2.4
0			JAMES TANSIND		300 Anns		E 170	3H K	られいた	THE 171	0 21201
	Sta Regist		31. Date filed (Month) Aay Year)	2005 32. J egist	rar's Signature	barte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 7:40 Q.M Thrower Januari 2,2000 JUANITA /Medical Eacility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore ranklin Kosedale Hospital 7. Age (In yrs. last birthday) Lace Birthplace (State or Foreign Country) Ma If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1□M 20F Months 214 14 968/ Usual Residence of Decedent Director DECEMBER filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or items 23a or 28a-f show other treumetic event, the Medical Examiner must be notified at Yes 2 No Completed by Funeral Director Altimone 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8 45.1. 21213 1300 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2 ANO Maryland 21215-0036 1 ☐ Yes 2 ☐ Ne Specify: If Yes, Give Year or Dates: Specify: BlACK 3 Widowed 4 Privorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. markad other than Elementary/Secondary (0-12) College (1-4or 5+) omestic 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) es 1 and 2 should ba fill of Health and Mental Hi Be SAMES ThrowER HANNAh Woods 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ATTER Bartiment MD ZIZET Joyce WILKENS Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or of 2056. Burial 2 Cremation 3 Removal from State 1+ ZION CEMETERY 110/06 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Add ss of Facility BEHS EUNERAL Home Betts BAI fiming MD ZIZI3 attres CANDINE St 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) upper gastroentestinal but to (or as e consequence of): Physician /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be exacuted Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed

To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifies

Mrower,

Completed Be ပ funeral Certification; filled in by the

Medical

State Registrar

2□ No 2 No 1 Yes

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

42106

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

5 Pending investigation

6 ☐ Could not be

determined

29c. License number D 6133 29d. Date signed (Month, Day, Year)

x J, MD, 9000 Franklin Square Drive, Baltimore, MD, 21237
32. Redistrar's Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nmed,

31. Date filed (Month, Day, Year) JAN 1 2006

25. Was case referred to medical examiner?

29b. Signature and title of certifier

Kirmara

1 ☐ Yes 2 ☐ No

27. Manner of Death 1 Natural

2 Accident

3 🗌 Suicide

4 Thomicide

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 00130 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Tracy 01 /Medical Loretta 06 8:25p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Director 73 212-28-8697 Usual Residence of Decede 27 VA 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worde. r than "nature!", or iteme 23a or 28a-f ehov the Madical Examiner must be notified at 1 ☐ Yes 2X No Director Silver Spring MD Montgomery 10e Street and Number 10g. Citizen of What Country? 14212 Weeping Willow Dr. 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 2 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LPN Rosewood Hospital llth grade d 2 should be filed with and Mental Hygie. 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Cornelius Stone Phoebe Henderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 20906 19a. Informant's Name/Relationship (Type, Print) Peges 1 and 2 s mant of Health an ant: if item 27 is: ury or other treus 20b. Place of Disposition (Name of cemetery, crematory or other place)

14212 Weeping Willow Dr.

Date Silver Spring #22, Deborah Jones-Daughter
20a. Method of Disposition Baltimore, 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pege Department of Importent: if eny injury or once. 1/13/06 Loudon_Park Baltimore, Md 21. Signature of Funeral Service License 22. Name and Address of Facility
March F/H West March F/H West 4300 Wabash Ave, Baltimo 4300 Wabash Ave, Baltimo shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Sepsis /Medical Due to (or as a consequence of): Examiner Sacral Decubiti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner physicien and the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical USB as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ò in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, certificate hes been significator, page 2 should be Congestive Heart Failure 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Renal Failure autopsy rmed? 2∭No Division of Vital 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death, Director: Aft d in by the fur 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funeral C completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie DOO 63343 108/06 30. Name and and ess of rerson who completed cause of death (Item 23a) (Type, Print) Irina Ruban, 1500 Forest Glen Road, Silver Spring, Md 31. Date filed (Month, Day, Kear) State Registrar

		4	State of Maryland / Department of Health and N 1- State Registrar Certificate of Death		ene2 0 0 6	00431
	Dhymini		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Tammy Lou Taylor		2006	5:45 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) Clinton Nursing & Rehab Center 4b. City, Town, or Location of Death Clinton			George's
	Funeral Director		5. Social Security Number 577 98 4290 6. Sex 1 M 2 T F 39 Yrs. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Jan 19,	^{9. Bi} 1966 Ma	rthplace (State or Foreign country) ryland
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryl	tor	Maryland Prince George's Clinton			1 □Yes 2 □ No XX
	n the	Director	10e. Street and Number 10f. Zip Code	100	J. Citizen of What C	
	23e c		7912 Bellefonte Lane 20735		United	States
	er dea terms	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
36	rs afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give A 1 □ Yes 2 □ No Specify: Year or Dates:		Specify:	White
9	2 hou ature	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	16	b. Kind of Busines	White s/Industry
215	thin 7 e. an "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Deliver	King	Top Ban	
2	filed within 72 hours after death with the Maryland Hygiene. the than "naturel", or Items 23e or 28e-f show the than "naturel", or Items 25e or 28e-f show ant, the Medical Evaning must be notified at		9th	- /F: . N/ . W		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or items 23e or 28e-1 show any injury or other treumetic event, the Medical Examinst must be notified at 2008.	To Be	John Olivon Toylon	ne <i>(First, Middle, Ma</i> Bbeth E. H		
ary	shoul tnd Ma s marl umeti	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru.	ral Route Number, (City or Town, State,	Zip Code)
ž	and 2 valth a valth a valth a valth a er tre		Tanya Adams (Daughter) 3983 Wintergreen Place	e. Waldor	f. MD 20	FO2
altimore,	of He of He If item				c. Location - City o	r Town, State
tim	tment tent: tent:		'4 □Donation 5 □Other (Specify) Lee Crematory Jan 9, 2006		linton, N	
Ba	Dep Impo any ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Le			20735
			23a. Part1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Priysician /Medical	91	Immediate Cause (Final disease or condition resulting in death)	11/		roupe
*	Examiner		Due to (or as a sonsequence of):	hund		11 on The
L,		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence c.).	*		7000
V	cuted nd ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c			
90,	cate be executed physician and the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):			
38760,	physies the b	dical	d			
Box 6	death certifi e attending id for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	alivery
	that the death certifi ed by the attending I detached for use as	Physician/M	In the past 12 months? 1 Yes 2 No 1 Yes 2 No		Month	Day Year
P.O.	that the ed by th detache	Phys	9 DAKIOWII	02a Did taba		to the save of death?
	ires tha signed d be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	. /	robably 4 Unknown
Records,	law requires as been sign 2 should be	Completed		24a. Was an	24b. Were a	utopsy findings available
Re	0 4 0	duic		autopsy performe	prior to death?	completion of cause of
Vital	icien: Th certificate rector, pag	0	25. Was case referred to medical 26. Place of Dea	th (Check only one)	3-No 1 □ Ye	S 2 140
of V	dii ya	To B	examiner? 1 Yes 2 No	ome 5 ☐ Resid <i>e</i> nd	ce 6 □Other (Sp.	ecify)
ם ח			27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Injury 28b. Time of 10 28c. Injury at 16 28c. Injur	28d. Describe how	injury occurred	
Division	Attending r death. sctor: After by the fune	ertification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined determined	28f Location (Stre	et and Number or F	Jural Route Number,
Div	in Line	ertif	4 Homicide determined building, etc. (Specify)	City or Town.		arar route reambor,
	To the Hospitel or Attend within 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the cau rred at the time, date	se(s) and manner a a and place, and du	s stated. e to the cause(s)
	Fo the Mithin Fo the comple	Me	29b. Signature and title of certifier 29o. License number	290	. Date signed (Mor	th, Day, Year)
			D19431		1/9/06	>
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TASK MINANNO 1101 MINATON 10 #103 7	F Wash	NETOU!	40) 20744
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	1: "	4,-	,,,
	Registr	ar	MAN T 1 2006			

PO 1	U_	1. Decedent's Name (First, Middle, Las	")		rtificate (2. Date of Dea			3. Time of Death
Physici /Medic		MARIAN	D. TONE					Month January	Day 3 _ 200	Year 6	2:47AM '
Examin	ier	4a. Facility Name (If not institution, give Southern Maryland	l Hospital		C1	vn, or Location Linton		,	4c. County Prin	of Death	eorge's
Funeral Director		5. Social Security Number 6. Security 125-16-9077 1 Usual Residence of Decedent	7. Age (In yrs. Ia	est birthday) Yrs.	If Under 1 Y Months Da	ear If Unde ays Hours	r 24 Hrs. Min.	8. Date of Birth (Month, Day, APTIL 2	5,1926	9. Birthp Coun NEV	lace (State or Forei try) York
aryland ehow	<u>.</u>	10a. State 10b. County	1	, Town or Lo						1	0d. Inside City Limi
728a-1	Director	Maryland Prince Ge	eorge's		Clint			1	0g. Citizen of W	/hat Coun	1 Yes 2 1
ath with	rai Di	6205 Runnymeade	Avenue		10.1.2.000	20735		'	og. Olizari di Vi	U.S.	•
ours affer de ral', or items Exeminer m	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	ľ	Was Decedent f Yes, specify (1 Yes 2			ecify Yes or No- Rican, etc.)		- Americ k, White, c Whi	etc.
z should be liled within 12 hours after death with the Maryland and Mental Hygiene. le marked other than "natural", or iteme 23a or 28a-f ehow aumatic event, the Medical Examination must be notified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 2 t h	cation (e completed) College (1-4or 5+)	(Give life. l	dent's Usual Ockind of work do DO NOT use re	ccupation one during mos atired)	st of worki	ng	16b. Kind of Bu	siness/Ind	lustry
uld be tiled fental Hygi rked other tic event,	To Be Co	17. Father's Name (First, Middle, Last) Daniel Bre	een	110111	omatic:		er's Name rion	(First, Middle, M	Maiden Sumam		
permit rages I and 2 should of Depertment of Health and Menta Important: If Item 27 is marked any Injury or other traumatic events.	-	19a. Informant's Name/Relationship (7) Thomas W. Tone (H						l Route Number,			
of Heall		20a. Method of Disposition 1 Burial 2 Cremation 3	20b. Pla		Sition (Name of natory or other		-	Clinton	n, Mary. 20c. Location - (
rtment rtent: rtent: h njury o		4 Donation 5 Other (Specify,	Lee	Crem	atory		2006		Clinton	n, Ma	ryland
Depe Impo		21. Signature of Funeral Service Closes	L 1200153	5 6	. Name and Ad 633 01d	dress of Facili ALexai	™ Lee ndria	Funeral Ferry I	l Home, Road Cl:	Inc. inton	, MD2073.
THA		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death.								Approximate Interval Between
hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	ince of).	neum	mitis					Onset and Death
xaminer	_	Sequentially list conditions,	Acute C	rebn	0 145	avan	AC	cident	_		
dansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	ince of):	SP.1h	odau t	1 H	oft her	tel 1Re	c./	
hysician and the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a conseque) 5) (m	janglia	Inf	arct	J. Jon	nai just	KI!	
	/Med	IF FEMALE:	30 Hugo outcome of consequent								
ed by the attending p	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	3c. If yes, outcome of pregnand 1	eath 3□	Ectopic pregna Other (specify,				23d. Date Mont		y Day Year
een signed by	by P	Part II. Other significant conditions co	ntributing to death but not result	ing in the un	derlying cause	given in Part I		23e. Did toba	acco use contrit	oute to the	cause of death?
been si	eted	CODD	Briting	isia	re)				_	Proba	
certificate has rector, page 2		COPP						24a. Was an autopsy perform	ed? de	ere autop: or to com ath? Yes 2	sy findings available pletion of cause of
this certific	To Be	25. Was case referred to medical examiner? 1 🕅 Yes 25 No.	ospital: 1	R/Outpatient	3 DOA	O#		Check only one e 5 ☐ Resider		(6	
le le	ation:	27. Manner of Death 1		8b. Time of Injury	28c. Ir	njury at Work?	2	8d. Describe how			
after de	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom- building, etc. (Specify)	e, farm, stre	et, factory, office	Ce	2	Bf. Location (Stre City or Town,	eet and Number State)	or Rural	Route Number,
	Medical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my knowle her: On the basis of examination and manner stated.	edge, death n and/or invi	occurred at the estigation, in m	time, date and y opinion, deat	d place, ar th occurre	nd due to the cau d at the time, dat	use(s) and mann e and place, an	ner as star d due to t	ted. he cause(s)
within To th	×	29b. Signature and title of certifier				062	700		Date signed of South 735		
		1100001	mpleted cause of death (Item 2:		~ 0	000	-01	MD. 20	W))	1000

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Marcelle R. Treutle 9:45a /Medical January 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Long View Nursing Home Manchester Carroll If Under 1 Year | ff Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2/ F 071-01-3270 Director Dec 23 1914 NY Usual Residence of Decedent filed within 72 hours atter death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "naturel", or Items 23a or 28a-f show the Medical Examiner must be nutified at 10d. Inside City Limits Мд Carroll Director Manchester 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3332 Main Street 21102 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☐ No δ Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) bakery worker food service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles R. Mumpton Rose Levain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other treu once. Joyce Rodo (daughter) 704 Wood Hill Dr., Jacksonville, FL 32256 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 1-6-06 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee) Pagespight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner hn 0 Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last we Due to (or as a consequence of) attending physician and for use as the burial-transit to the Hospital or Attending Physicien: The law requires that the death certificate be executed tspi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 XNo cate has t 2100 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA : Atter this tuneral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No filled in by the t 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funerel L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 51705 DR, Westminster my 21157 ted cause of death (Item 23a) (Type. Print) 30. Name and address of person who complete Malbolm ANSURI 32. Restrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 1 2006 Registrar

		1	For State of Ma	aryland / De	epartment of Certificate	of Health and N of Death		ene 2006	00431
Ph	ıysicia		I. Decedent's Name (First, Middle, Last) Louis J. Teller				2. Date of Death		3. Time of Death 11:25 p M
	Medica kamine		a. Facility Name (If not institution, give street and number) Atlantic General Hospital	,		wn, or Location of Death	1	4c. County of Death	J
	neral ector		•	e (In yrs. last birthe	day) If Under 1 \		8. Date of Birth		place (State or Foreign try)
166			Jsual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				0d. Inside City Limits
the Mary 28a-f sh	stiffed	ector	MD Worcester 10e. Street and Number	Ocean	City 10f. Zip Co		146	Cisi	1 X Yes 2 □ No
ath with	uat be	Funeral Director	3001 Atlantic Avenue			842		g. Citizen of What Coul	ntry ?
036 ours after des	Examinar	۵	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ ∑Yes 2 □ N I Yes, Give Year or Dates:		13. Was Deceden If Yes, specify 1 ☐ Yes 2 ☑	t of Hispanic Origin? (Sj Cuban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify:	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Impordent: If the 71 is marked other than "natural", or Itams 23a or 28a-7 show	ibe Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5		ecedent's Usual C Give kind of work of fe. DO NOT use i Plumber	tone during most of wor etired)	king	6b. Kind of Business/In	dustry
and and a state of the files	svent,	Be	17. Father's Name (First, Middle, Last) Louis J. Teller	Sr		18. Mother's Nam	ne (First, Middle, M	aiden Sumame) Saltys	iak
Maryland Id 2 should be file th and Mental Hy 27 is marked oth	raumatik	2	19a. Informant's Name/Relationship (Type, Print)	19b. N	-	treet and Number or Ru	ral Route Number,	City or Town, State, Zip	Code)
Ore, N	or other t	-	Bonnie Baker-daughter 20a. Method of Disposition 1 🖄 Burial 2 🗆 Cremation 3 🗆 Removal from State	20b. Place of D	isposition (Name crematory or othe	Brook Rd.	Date 2	Oc. Location - City or To	own, State
Baltimore, Permit: Pages 1 a Department of Mes	ny Injury ICe.	ĺ	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee William	!		Address of Facility Ruc	ck Towson	Bel Air, MD Funeral Ho	
W 83 5	# B		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each life	the death. Do по		k Rd., Tows		21 204 st,	Approximate Interval Between
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Teller 36 78 ds, P. ds, p.	p e	۾	Part II. Other significant conditions contributing to death b	ut not resulting in t	he underlying caus	se given in Part I.		acco use contribute to to	
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Z / Z / Z / Z / Z / Z / Z / Z / Z / Z /	irector.	o Be C	25. Was case referred to medical examiner? 1 □ Yes 2 ⊠No Hospital: 1 ⊠npatie	int 2□ER/Outp		Othor	th (Check only one)	
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Division To the Hospital or Attending within 24 hours after death.	in by the	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Inj building, et	ury - At home, fam c. (Specify)			28f. Location (Str City or Town	eet and Number or Rura State)	al Route Number,
Hospital	completely filled in by the	edical Ce	29a. Certifier (Check only cond.) 2 Medical Examiner: On the basis of	of my knowledge, of examination and/	death occurred at to investigation, in	he time, date and place my opinion, death occu	, and due to the ca	use(s) and manner as s te and place, and due to	tated.
To the within 2	complet	Med	one) and manner sta	ited.		icense number		d. Date signed (Month,	
			30. Name and/address of person who completed cause of d	eath (Item 23a) (T	ype, Print)	005 37 14		1/6/06	
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4.	Physic /Medi		1. Decedent's Name (First, Middle, La	Tran				2. Date of Dea Month	Day Y	3. Time of Death				
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¥	Funeral Director		212.92.5542 Usual Residence of Decedent	□M 2X□F 81	yrs. last birthday) Yrs.	Months Days	Hours Min		Vaarl	Birthplace (State or Foreign Country) ietnam				
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	th with the 23a or 28 ust be no	ai Director	10e. Street and Number 11807 Bare Sky	Lane.		10f. Zip Code 2104	4	1	0g. Citizen of Wha	at Country?				
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21215-0	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-1 show event, the Medical Examiner must be notified at	Completed	15. Decedent's E. (Specify only highest gra	ducation ide completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done di DO NOT use retired) emaker	tion uring most of wo	rking	16b. Kind of Busin	•				
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	is 1 and 2 should of Health and Mer item 27 is marks other traumatic		19a. Informant's Name/Relationship (Bach-Tuyet Thi Tr	an-Jeffrey	1180	g Address (Street a.)7 Bare Sk		olumbia,M		te, Zip Code)				
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State M		ematory or other place		2006	20c. Location - Cit Catonsvil	le,Md				
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Daltimore, Maryialin 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	eny ir		Dona di ina	1	01/07	Дç	naldson 11 Annap	Funer	al Ho	me & C	rema	tory, I	P.A.
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To the Hospital or Attending I	lo the Funerel Director: Atter this certificate his completely filled in by the funeral director, page	aic	29a. Certifier Certifying	Physician: To the best of	my knowle	dge, death	occurred at the time	e, date and	place, and	due to the c	ause(s) a	and manner as	stated.
9 Ho	e Fu	edical	(Check only 2 Medical E)	aminer: On the basis of e	examination ed.	and/or inve	estigation, in my op	inion, death	occurred a	at the time, o	date and p	olace, and due t	to the cause(s)
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DHMH 17 Rev 1/2001

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Funeral Director			X 2□ F		rs. Months		Hours	Min.	B. Date of Birt (Month, Day 05	y, _{Year)} 3 64	Cou	place (State or Foreign Intry) MD
P J		Usual Residence of Decedent										
laryia shov	jo.	10a. State 10b. County		10c. City, Town								10d. Inside City Limits Yes 2 □ No
the N 28a-i	rect	MD NA 10e. Street and Number		Balti		ip Code				10g. Citizen o	f What Cou	
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or Its	by Funeral Director	1 Never Married 2 ☐ Married	1 Tes 2		1 ☐ Yes		Specify:	- dento m	ican, etc.,	Spec	ack, White	
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in 72	oiete	15. Decedent's Ed (Specify only highest gra	de completed)		Decedent's Us (Give kind of w life. DO NOT	ual Occup rork done d use retired	ation du <i>ring</i> most (d)	of working	7	16b. Kind of	Business/ir	ndustry
yiding XIXIS-DUSO ould be filed within 72 hours after death with the Maryland Merial Hygiene. arked other than "natural", or Items 23a or 28a-f show atto event, it a Madical Examinal must be notilised at	Completed	12th grade	College (1-4or	5+)	Chef					Re	stau	rant
d be filed and the filed and the filed other c event,	Bec	17. Father's Name (First, Middle, Last)					18. Mother	's Name (First, Middle,	Maiden Sum	ame)	
Should bent marked umatice		Richard Edward	Walton S						R. Fow			
2 sho		19a. Informant's Name/Relationship (7			Mailing Addres							
ire, Mary variation 2 12.13-0030 s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental hygiene 14 the marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Madical Exemination must be notilised at		Mattie R. Walto 20a. Method of Disposition	on-Motne					Dau /		20c. Location		
Dallinore, permit. Pages 1 an Oepertment of Heal Important; If item 2 eny Injury or other	- 5	Multiple of Supposition 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify									-	
Dallillor Demit. Pages Depertment of Important; If it iny Injury or o		21. Signature of Euneral Service Licen		King	Memori 22. Name a	and Addres	ss of Facility	,	5/06	Randa	IISC	own, Md
Depermine Permi		mette	JK.Y	mes)	March	ı F/I Waba	H Wes	t ve.	Balti	more,	БМ	21215
		23a. Part1. Enter the disease, or composhock, or heart failure. List only	olications that sause	d the death. Do n							- 110	Approximate Interval Between
Physician	ı.	Immediate Cause (Final disease or condition	· (a	RCINO	NA O	L 11	ing					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequence o			- /					7/13
Ladifille	ē	Sequentially list conditions,	b. — Davids Fire		P.							
ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D09 to (0) as	a consequence o	n);							
execunand and al-tra	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence o	f):							
BOX 501 00, eath certificate be executed attending physician and for use as the burial-transit	cail		d									
ntifical ng phy as th		IC FEMALE.										
ath ce trendii	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	of pregnancy 2 Petal death	3 Ectopic	pregnancy					ate of deliv	ery Day Year
S, F.O. BOX es that the death cer igned by the attendir be detached for use	Physician/Med	1 Yes 2 No	4□Pregnant a 9□Unknown	t time of death	5 Other (s	specify)				,	TOTAL	Day 18ai
that the ed by detac	Ph	Part II. Other significant conditions of	ontributing to death b	out not resulting in	the underlying	cause give	en in Part I.	VIV.	23e. Did to	bacco use co	ntribute to 1	the cause of death?
The Coulds, F.O. BOX 60/00, The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	d by			·	, ,				1 🗆 Y			bably 4 Unknown
tw requir	Completed								24a. Was	an 24b	. Were auto	opsy findings available
The lav	отр								autop perfor	sy /	prior to co death? 1 \(\subseteq \text{Yes}	impletion of cause of
VICIAN: The certificate rector, pag	BeC	25. Was case referred to medical	S and				26. Place o	of Death	1 Yes Check only or	A	1 1 103	2 140
Ol VICAL Physician: r this certifice ral director, p	ToE	examiner? 1 □ Yes 2 No	Hospital: 1 🗌 Inpati		patient 3 🗆 🗅	Oth	er: 4 🗆 Nurs	sing Home	e 5 ☐ Resid	lence 6 0	ther (Spec	not Home
oding P th. After t		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Ti		28c. Injury Work			d. Describe h	low injury occi	urred	V
Attending or death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		jury - At home, far	M Street factor		Yes 2 □ N		of Location /S	Stroot and Mus	abor or Due	al Route Number,
DIVISION al or Attendir after death. I Director: After to the	Certification:	4 Homicide determined	building, e	tc. (Specify)	m, street, racto	ry, once		20	City or Tow	n, State)	IDEL OF HUI	ar Houte (vumber,
spita hours ineral y filled		29a. Certifier 12 Certifying Ph	ysicien: To the best	of my knowledge,	death occurre	d at the tim	ne, date and	place, an	d due to the	ause(s) and r	nanner as s	stated.
To the Hospital or Attending Physician: The law within Z4 butus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 ☐ Medical Examone)	iner: On the basis of and manner st	ated.				n occurred	at the time, o	date and place	, and due t	o the cause(s)
To To To Com	Σ	29b. Signature and title of certifier	Clark	II MD	2:	9c. License	- · · · · · · · · · · · · · · · · · · ·	^		29d. Date sign	ed (Month,	Day, Year)
1		Priceculary	4/14				3340	0		UIJO	1/2	
1.		30. Name and address of person who	completed cause of a	leath (Item 23a) (Type, Print)	arlo	s St	Bal	Chron	LU) 71	212
Sta	te	31. Date filed (Month, Day, Year)	32. Regign	ar's Signature	- 1001		- 01	1-00		1	2-16	~ 1 Cm
Registr		JAN I 1	2005	evic S.	6034	Ker .						

			1 - For State Registrar		State o	f Maryla	ind / Depa	artmen rtificate	t of H	ealth a	and M	lental H	ygier Reg. 1	220 00 0	16	0043	B
			Decedent's Name (First, Mi	ddle, Last,)							2. Date of I	Death			3. Time of Death	
	Physic /Medi		CATHERIA	16				WIL	LIA	ms		JAMU/	ARY		Year LCO6	2.58 A	А
)	Exami		4a. Facility Name (If not institu			mber)		4b. City,	Town, or	Location	of Death	, , , , ,		c. County o			
			9000 SAMA	RIT	AN	KOSPI		BI		IMO	RE			BALTI			
L	Funeral Director		5. Social Security Number 212-03-6002	6. Se:	×]м 2 ў] F	7. Age (In yr 96	s. last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of E (Month, I Oct. 2	Birth Day, Yea 22,	1909	9. Birthp Cour Ma	lace <i>(St</i> ate or Foreig try) cyland	IU
	land		Usual Residence of Decedent 10a. State 10b. Cou	nty		10c. (City, Town or Lo	cation							1	0d. Inside City Limit	s
	the Maryland r 28a-f show	to	Maryland H	larfo	rd		Bel	air ~	Har	ford	Co.					1 ☐ Yes 2√√N	
	or 28a	lrec	10e. Street and Number					10f. Zip	Code				10g. (Citizen of W	nat Cour	try?	_
	th wit	alD	300 W. Ring Fa	actor	y Rd.	#209			2	1014				USA			
	r dea	ner	11. Marital Status		12. Was Dece Armed Fo	rces?	U.S. 13.	Was Deced	ent of Hi	spanic Or	gin? (Spe	ecify Yes or h	No-	14. Race Black	Americ White,		
36	rs afte	by Funeral Director	1 ☐ Never Married 2 ☐ N 3 ☐ Widowed 🎸 Divord		1 ☐ Yes If Yes, Giv Year or D	/e	j	1 ☐ Yes 2		Specify:				Specify:	Wh:		
215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show after Examiner must be notified at	ted	15. Deced	lent's Edu	cation	ates.	16a. Dece	dent's Usua	I Occupa	tion	-		16b	Kind of Bus	ness/Inc	lustry	
215	hin 7: 9. Medi	Completed	(Specify only hig			I-4or 5+)	(Give	kind of wor DO NOT us	k done d e retired)	uring mos	t of worki	ing	100.	11110 01 000		, do (,)	
2	ed wit	Сол	12 yrs.		N/A		Tre	asure	r				С	. & Р.	Te:	Lephone Co	э.
Maryland	perriit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene Important; if item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, Ira Medical Examinar must be 2015.	To Be	17. Father's Name (First, Midd Charles Gettie	-,,								(First, Midd reufe		en Sumame)		
lary	2 shoil		19a. Informant's Name/Relation									i Route Num					
	and and magnitudes		Patricia S. Wi	sel_	(Grand		- 25	-		ing V	voods	s Way I	Bela	ir, Mo	1. 2	1014	
Baltimore,	ges 1 t of H If itel		20a. Method of Disposition XIX Burial 2 ☐ Crematic	n 3 □ A	lemoval from	a !	Place of Dispo cemetery, crer	natory or ot	her place			ate		Location - C			
Ë	t Partmen tent:		`4 ☐ Donation 5 ☐ Other	(Specify)		Pa	rkwood					2006	Ва	ltimor	e, N	ſd.	
Bal	Departing any ir		21. Signature of Funeral Servi	SPO		<u>ئے</u>	22	Lassa 7401				lome altımo	ore.	Md. 2	1236))	
			23a. Part1. Enter the discase shock, or heart failure. L	or compli	ications that c	aused the de ach line.	ath. Do not ent									Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	a	· ·	SEP	515								Ó	Onset and Death	C
	/Medical Examiner		resulting in death)		Due to	or as a conse									-		
		Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	t	Due to	or as a conse	AMON	114	_						f.	NO WEEK	ت-
	uted d ansit	Examiner	Cause (Disease of liffuly	<			14201100 01).										
á	icafe be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last	and the second	Due to (or as a conse	equence of):										
68760,	ife be nysicia he bui	dlcat			1												
_	eath certificate be executed attending physician and for use as the burial-transit	0.0	IF FEMALE:														
Вох	The law requires that the death certif ale has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	2		irth 2 ☐ Fe	tal death 3 □	Ectopic pre						23d. Date Month		ry Day Year	- 1
	the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown		4∐Pregn 9□ Unkno	ant at time of	death 5	Other (spe	cify)					IVIOLITI	,	Day (ea)	
P.O.	res that the designed by the	/Ph	Part II. Other significant cond	itions con	tributing to de	eath but not re	sulting in the ur	ndertying ca	use give	n in Part I.		23e. Did	tobacco	use contrib	ute to th	e cause of death?	7
Records,	uires sign	d by			mo			, ,	•			1	Yes :	2 No 3	☐ Proba	ably 4 🗆 Unknow	1
000	w requir s been si should	lete	HYPOTH	120	BISK	21						24a. Wa	s an	24b We	re autor	sy findings available	
Re	The lay	Completed	ATRIAL				T					auto	opsy formed?	pride	or to con ath?	ipletion of cause of	
Vital	icien: Th certificate rector, pag	a l	25. Was case referred to medi		TISA	ICCA	TION			26. Place	of Death	1 Yes	2XN	0 1L	Yes	2 X No	
of V	hysicien: nis certific I director,	To B	examiner? 1 ☐ Yes 2 No	Н	ospital:	npatient 2[☐ ER/Outpatien	3 DO				ne 5□Res		6 ☐Other	(Specify)	
0 0	ding Pth I. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pen	dina	28a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury	28	c. Injury Work	at	2	8d. Describe	how inj	ury occurred			
Division	Attendii er death. rector: A by the fu	Certification;		stigation				М		es 2 🗆 !	No						
Σ	affer of Direc	ırtiffi	4 Homicide dete	mined	28e. Place buildir	of Injury - At I	home, farm, stre hify)	et, factory,	office		2	28f. Location City or To			or Rural	Route Number,	
	ours source source		29a. Certifier 1 Certif	vina Phys	ician: To the	heet of my kr	lowledge, death	Occurred a	t the time	data as	d place a	and due to the		-) and			_
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Medical	(Check only 2 Medic	al Examir	ner: On the ba	isis of examin	ation and/or inv	estigation, i	in my opi	nion, deal	th occurre	ed at the time	, date ar	nd place, and	er as sta d due to	the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certi	fier	" //			29c.	License	number			29d. D	ate signed (Month, E	Day, Year)	
	-01		1 /sh	Si	lle		an		00	77	8		JAN	MAR	4	1 2006	5
j	751		30. Name and address of person	on who co	mpleted caus	e of death (Ite	m 23a) (Type, I	Print)		1.	u 7	0		(())		1, 2006 mp 212	
0	~		RAPHAEZ	0	0000	5	607	104	4 /	AV	524	1200	BA	LTIM	ORE	mp 212	79
	Sta Registr	1 4	31. Date filed (Month, Day, Ye. JAN 1	200	S R	egistrar's Sign	ature	egs. P									

Michelle Denton 06-00015 CPM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma		Depa		of He		lental Hygi		006	00439
	I		1. Decedent's Name (First, Middle, La	st)						2. Date of Death Month	Day	Year	3. Time of Death
	ysicia Nedic		Michele T. Waters -	Denton						January		2006	10:30 A ^M
	amin		4a. Facility Name (If not institution, give	street and number)			4b. City, Tov	vn, or	Location of Death		1	nty of Death	
			University Hospita	al-Shock T	rauma				Ltimore				
	eral		5. Social Security Number UNIC 6. S	ex 7. Age □M 2 🔀 F	(In yrs. last bit		Months D	ear ays	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 09-19-195	Year)	Coun	lace (State or Foreign
Dire	ctor	-	Usual Residence of Decedent		49	Yrs.				09-19-195	06	Mary	land
and	=	-	10a. State 10b. County		10c. City, Tow	m or Lo	cation					1	0d. Inside City Limits
Mary -1 •h	7	ō	MD NA				Baltimor						1 XYes 2 No
1 the	Total	Director	10e. Street and Number				10f. Zip Co			10	g. Citizen	of Whal Coun	try?
h with	2	0	503 N. Schroeder Str	eet				2122	23		US	!Δ	
deat	P P	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. V	1		spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-	14. F	Race - Americ	
after or its	8		1 Never Married 2 Married	1 ☐ Yes 2XX	lo		□ Yes 2X		Specify:	riidan, etc.)		Black, White,	erc.
Z1Z13-UU36 d within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28e-f ehow	the Medical Examinar must be notified at	d by	3 ☐ Widowed 4 X Divorced	Year or Dates:								lack	
72 r	ed l	Completed	15. Decedent's Ed (Specify only highest gra		16a	(Give	lent's Usual O kind of work d OO NOT use n	one du	uring most of work	ing 1	16b. Kind o	f Business/Ind	dustry
within 72 ene.	5 P	Ę.	Elementary/Secondary (0-12)	College (1-4or 5 2	+)	mo. L	Nurse				He	alth Car	~
	nt,		17. Father's Name (First, Middle, Last)						18. Mother's Name	e (First, Middle, M			.e
Vian Vian Mental Arked o	•	To Be	Wiley Junius Waters						Joan M	oss Garner	_Tollo	•	
Taryla 2 should and Men is marks	mat	-	19a. Informant's Name/Relationship (Type, Print)	198	o. Mailin	g Address (St	reet ar	nd Number or Rura				Code)
and 2 and 2 lealth a m 27 is	2		Jean M. Garner-Toller	/ Mother	50	03 N.	Schroe	ier	Street Bal	to, MD 212	23		
S 1 ar	othe		20a. Method of Disposition				sition (Name of					on - City or To	wn, State
Pages nent of int: If It	ار ار		1 ♣ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		1 .		orial Pa		01-09-0	06	Baltim	ore. MD	
Baltimore, Maryland permit. Pages 1 and 2 should be file Deperment of Health and Mental Hys Important: If Item 27 is marked oth	any Inju		21. Signature of Funeral Service Licer	S00		22	. Name and A	ddress	of Facility			ore, in	
n && =	# SI		1/pm			Wy	lie Fune	eral	Home P.A.	638 N. Gi	lmor S	t. Balti	more, MD 21217
Physic / Med Exam parameter physicien and parameter physicien and parameter physicien and parameter physicien and parameter physicien and parameter physicien and parameter physicien and parameter physicien and parameter physicien and parameter physicien and physicien	iner iner	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a c.	a consequence	of): Uf):	FORC	G	INTVRI	E.7.			Onset and Death
rtifical ng ph			IF FEMALE:										
j	ached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregn Other (specif				1	Date of delive Month	ry Day Year
<u> </u>	Pe Pe	۵	Part II. Other significant conditions of	ontributing to death bu	ut not resulting i	in the un	derlying caus	e giver	n in Part I.	1	accouse c		e cause of death? abiy 4 Unknown
	9 2	Completed								24a. Was an autopsy perform	ed?	prior to con death?	osy findings available inpletion of cause of 2 No
VITAL F sician: The certificate	rector,	Be (25. Was case referred to medical examiner?	Manufat:					26. Place of Death	Check only one	1		
Physic This c	<u>a</u>	၉	Yes 2 No	Hospital: 1 Inpatie			3□ DOA	Other	4 Nursing Ho	me 5 Resider)
Affer	funer	<u>ö</u>	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Dale of Injur	Year)	Time of Injury		Work	?	28d. Describe how	winjury occ WASS	STABBEL	AND WIT
DIVISION I or Attending after death. Director: Afte	the the	cat	2 Accident investigation 3 Suicide 6 Could not be			00	T		223,10	28f. Location (Str.			- 7
DIVISION ARTEN after deat Director:	i D	Certification:	4 Momicide determined	building, etc	: (Specify)	ann, otte	out, ractory, or		1	City or Town,	State)		MOLE, MO
Hospital 24 hours a Funeral I	₽		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of		e, death	occurred at the	he time					
UIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	letely	Medicai		niner: On the basis of and manner sta	examination ar	nd/or inv	estigation, in	my opi	nion, death occurr	ed at the time, da	te and place	e, and due to	the cause(s)
To the within 2	comp	ž	29b. Signature and title of certifier				29c. Li	cense	number	29	d. Date sig	ned (Month, L	Day, Year)
			▶ ane IZ					0.0	C.M.E.	J	anuar	y 02,	2006
11			30. Name and address of person who				Print)						
	Sta	0	31. Date filed (Month, Day, Year)		r's Signature	TTT	reim 2	LLE	et, Balt	more, M	агута	110 ZIZ	OI
Re	egistr		JAN 1 1	2006			men						

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2 Date of Death

		1	1- State of Maryland / Department of Health and Mer Certificate of Death	Reg. No.	006	00440
	Physicis		1. Decedent's Name (First, Middle, Last) 2.	Date of Death Month Day		3. Time of Death
	Physicia /Medic	al -	SHIRLEY YOCUM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		County of Death	
	Examin	er	GOOD SAMARITAN HOSPITAL BALTIMORE		N/A	
	Funeral Director		205-12-2922 1 Months Days Hours Min. Ju	Date of Birth (Month, Day, Year) II y 28, 192	9. Birth	nplace (State or Foreign untry) INSylvania
	land land	—	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mary Be-f sh	ctor	MD Baltimore Baltimore	40. 00		1 Yes 2 No
	ath with the 23a or 2	ral Dire	6 Bushwood Road 21234	U.	S.A.	
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "neturel", or items 23a or 28e-f show other then "neturel", or items 23a or 28e-f show event, the Medical Erac dear must be notified at	by Fur	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricci If Yes, Sive Year or Dates:			a, etc. Ihite
15-0	n 72 h	letec	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	16b. Kir	nd of Business/I	Industry
212	d withi	Completed	Elementary/Secondary (0·12) College (1·4or 5+) 4 Registered Nurse		ealth Ca	are
and	should be filed within a Mental Hygiene. marked other then metic event, in Me	Be	17. Father's Name (First, Middle, Last) Walter Rhodes 18. Mother's Name (First, Middle, Last) Althe	irst, Middle, Maiden McGuskie	Sumame)	
aryle	should be and Mental s marked o umetic eve	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Ru		r Town, State, 2	Zip Code)
, M	d 2 th 2 tre		Mr. Lawrence Yocum- Son 9505 Kingscroft Terrace		ll, Mary	
Jore	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Commetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State			1aryland
altin	mit. Paramen bartmen content injury		21. Signature of Funeral Service Licensee Heather Cain 22. Name and Address of Facility Leo	onard J. F	Ruck, Ir	nc.
ä	Depar Impo eny ir		5305 Harford Road Ba		laryland	1 21214 Approximate
b			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. Immediate Cause (Final	sspiratory arrest,		Interval Between Onset and Death
1	/Medical		Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAIL Due to (or as a consequence of):	URE		
8	Examiner	L.	Sequentially list conditions, Due to for as a consequence off:			
	uted d ansit	Examiner	Sequentially list conditions, if a ry, is adoption addata cause. Enter Underlying Cause (Disease or injury that initiated events C.			
0,	ficate be executed physician and is the burial-transit		resulting in death) Last Due to (or as a consequence of):			
68760,	ificate b g physic as the b	edical	d			755-20
Box.	ath certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 5 □ Other (specify)		23d. Date of del Month	ivery Day Year
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ords	w require been sig should b				□No 3□Pr	
of Vital Records,	sicien: The law I certificate has bu lirector, page 2 sh	Completed		24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vita	Physicien: The ribis certificate har al director, page	Be	25. Was case referred to medical examiner? 1 Yes		6 □Other /Sne	city)
10	Phy this ral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Work?	d. Describe how injur		U.I.y/
Division	tending I leath. tor: After the funer	catio	2 Accident investigation M 1 Yes 2 No	f. Location (Street an	nd Number or Ri	ural Route Number
Divi	ofter d Direct Direct	Certification:	3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, State))	
	To the Hospitel or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	-03	29a. Certifier (Check only one) To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) at the time, date and	and manner as d place, and due	s stated. e to the cause(s)
)	To the vithir To the comp	Me	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier Manda Ball, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOCD SAMAR MANISHA BAHL, MD 31. Date filed (Month, Day, Year) JAN 1 1 2006 32. Registrar's Signature	3 JAN	te signed (Mont	10 2006
1	3 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GCCD SAMAR	ITAN H	OSPI 7	AL 21279
	St.	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ID ; ISAC	TIMORE	(1M1) 2123/
	Regist	rar	JAN 1 1 2006			

DHMH 17 Rev 1/2001

				For State Registrar	State	of Marylar	nd / Depa	artment of I	Health and Death	Mental H	/giene	006	004	41
			ş	Decedent's Name (First, Middle, L.	ast)					2. Date of D	eath		3. Time of	f Death
(1)		Physici /Medic		Chaae Pauline Yoon						01/09	/2006	Year	4:20	ам
		Examir		4a. Facility Name (If not institution, gi	ve street and nu	ım <i>ber)</i>		4b. City, Town,	or Location of Dea	th	4c. C	County of Death		
				GILCHRIST CENTER				Baltimo						
		Funeral Director		220-68-3891	Sex 1 □ M 2/□XF	7. Age (In yrs. 63	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birth Cou Kore	place (State on intry)	r Foreign
		and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside C	ity Limits
		Maryla fracti	ō	MD Howard			licott						1 🗌 Yes	•
		vith the M	Director	10e. Street and Number			110000	10f. Zip Code			10g. Citize	en of What Cou		
		23a o		3601 Rusty Rim				21043				USA		
		deat	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. \	Was Decedent of I	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or N	0- 14	4. Race - Ameri		
	98	or Ite		1 Never Married 2 Married		2 ∏No ive	1	1 □ Yes 25√2 No		to rican, etc.)		Black, White,	, etc.	
	8	hours ural',	d by	3 ☐ Widowed 4 🖔 Divorced	Year or I	Dates:						Asia		
	21215-0036	n 72	Completed	15. Decedent's E (Specify only highest g	ducation a <i>de completed,</i>		(Give	lent's Usual Occu kind of work done DO NOT use retire	during most of wa	rking	16b. Kind	d of Business/Ir	ndustry	
	12	withi Bne. than	mc.	Elementary/Secondary (0-12)	College (stered Nu	•		John!	's Hopk:	ins Ho	sni ta'
		2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23s or 28s-1 show raumatic event, the Medical Exercitor must be multified at	Be C	17. Father's Name (First, Middle, Las	t)		1109-1	00100 110		me (First, Middle	•		210 110	<u> </u>
M	Maryland	Ald be Alenta rked tic ev	To B	Unknown					Chaae Y	oon				
4	ary	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Number or R	ural Route Numi	oer, City or	Town, State, Zij	Code)	
42574		D = 1 = 0		Suzanne C. Choi/	Daughte				lerick Rd	., Ellic	cott (City, M	21043	3
3	ore	50 -0 -0		20a. Method of Disposition 1 Disposition 2 Cremation 3	□Bemoval from		Place of Dispo cemetery, cren	sition (Name of natory or other pla	ice)	Date	20c. Loca	ation - City or T	own, State	
0	Ë	Pages ment of P ant: If its ury or of	ļ	4 □ Donation 5 □ Other (Spec		Cres			dens 01/1	•	Marri	ottsvi	lle, M)
_1.	Baltimore,	permit. Page Department of Important: If any injury or once:		21. Signature of Funeral Service Lice	Hack	man	- Wi 55	Name and Addre tzke Fun 55 Twin	eral Hom Knolls R	es, INC	mbia.	MD 210	045	
B	Æ			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that	caused the deat							Approximat Interval Bet	ween
		Physician		Immediate Cause (Final disease or condition	, 5)	ch !	cance	1				Onset and I	Death
9		/Medical Examiner		resulting in death)	Due to	(or as a conseq								- 13
	1	Examine		Sequentially list conditions,	b									
2/0		ed isit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):							
1		and and II-tran	хап	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):							
	68760,	sician and burial-transit				,	,							
2	687	ficate physis the	edic		d									
Ired	Вох	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	itcome of pregna	Ideath 3□	Ectopic pregnanc	у		23	d. Date of deliv		Year
bu	P.O.	that the de ed by the a detached i	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr			Other (specify) _						
EXP	Vital Records, I	uires tha signed Id be de	d by F	Part II. Other significant conditions	contributing to o	leath but not res	ulting in the ur	nderlying cause gr	ven in Part I.		tobacco use Yes 2 😿	ocontribute to to		leath? Jnknown
	Ö	w requir been si should	Completed							24a. Wa:	an	24b. Were auto	nev findings	available
3	Re	The lavate has	шć							auto perf	psy omed?	prior to co death?	mpletion of c	ause of
yoon	ta	ician: Th certificate ector, pag	O	25. Was case referred to medical					26 Place of De	1 ☐ Yes ath (Check only	2 No	1 🗆 Yes	2 No	
5		Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2 🔼 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Ott		lome 5□Res		√Other (Specia	W) 0 = 0 0	2.5
1.	ιof	ding Ph h. After thi funeral		27. Manner of Death 1 ANatural 5 □ Pending	28a. Date	of Injury th, Day Year)	28b. Time of	28c. Inju Wo		28d. Describe			"VLOSE	110
15	Ö	Attendir death. ctor: Af y the fur	atic	2 ☐ Accident investigation	on	,,,	,,		Yes 2 □ No					
H.44E	Division	or July in b	Certification:	3 Suicide 6 Could not l 4 Homicide determined	28e. Płace build	e of Injury - At ho ling, etc. <i>(Specif</i>	ome, farm, stre	eet, factory, office		28f. Location City or To	Street and I wn, State)	Number or Rura	al Route Num	ber,
77		To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical C	29a. Certifier 17 Certifying P (Check only one)	miner: On the b	e best of my kno pasis of examina nner stated.	wledge, death tion and/or inv	occurred at the ti restigation, in my o	me, date and place opinion, death occi	a, and due to the urred at the time	cause(s) ar date and p	nd manner as s lace, and due to	tated. the cause(s)
		To th within Fo the	Me	29b. Signature and title of certifier	1			29c. Licens	se number		29d. Date :	signed (Month,	Day, Year)	
		-1'		K / D	λ			n	T 2 3 03		Janva	Pm	2005	
		191		30. Name and address of person who	completed cau	se of death (Item	23a) (Type, I	Print) (Us	58303 wlest	Bajan	ne v	W 212	U	
		Sta	ite	31. Date filed (Month, Day, Year)	32/1	Registrar's Signa	-							
		Registr	ar	JAN 1 1 2	006	Registrar's Signa	- Alle	Section 1						

			For Stete Registrer		State o	of Mary	land / Dep <i>Ce</i>		t of H	ealth a	and M	1	gienę Reg. Ne	006	0	0442
	Physici	an	Decedent's Name (First,	Middle, Las	t)							Date of Deal Month	ath Day	Yea	ır	ime of Death
1	/Medio	cal		Yvon				Arthu			(5)	1	_	2006		019a M
1	Examir	ier	4a. Facility Name (If not ins			imber)		4b. City,		Location			4c. (County of D	eath .	
- <u>-</u>	Funeral		424 E. 28t 5. Social Security Number	n Stre		7. Age (In	yrs. last birthday	If Under	1 Year	timo: If Under	24 Hrs.	8. Date of Birt	th ,	NA 9. E	3 inthplace (S	State or Foreign
	Director		215-56-3023	1	⊐м 2 Х јг	55	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 5-15	y. Year) -50		Country)	Md.
	pur &		Usual Residence of Deceded			100	c. City, Town or L	ocation							10d inc	ide City Limits
	Maryla f • ho	ō	Md.	NA			•	timor	A							Yes 2 No
	28a-	rect	10e. Street and Number	14/1			DQI	10f. Zip					10g. Citiz	en of What	Country?	
	th with	Funeral Director	424 E. 28	th Str	reet				21	218				US	Δ	
	ems (ner	11. Marital Status		12. Was Dec		in U.S. 13.	Was Deced			igin? (Spe	ecify Yes or No Rican, etc.)	- 1	4. Race - A Black, W	merican Indi	an,
36	safte , or it	by Fu	1 Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div		If Yes, Gi	2∕ No ive		1 Yes		Specify:					Black	
215-0036	within 72 hours after death with the Maryland ane. then "natural", or Items 23e or 28e-f ehow he Healtest Exemplier mout be notified at	ed	15. De	cedent's Ed	Year or D		16a, Dece	dent's Usua	al Occupa	ition			16b. Kir	d of Busine		
215	hin 72 9. "na Medik	Completed	(Specify only Elementary/Secondary (highest gra	de completed)) (1-4or 5+)	(Give	NOT us	rk done d se retired,	<i>uring</i> mos)	t of work	ng			,	A. Hal.
	filed withi Hygiene. Ither ther	Com	12th grade			401077	Tea	cher .	Aide				Ele	meter	y Scho	ool
pul	be file	Be	17. Father's Name (First, N	liddle, Last)			3 . (.)					(First, Middle,				Jackson
Maryland	should be nd Mental marked o	To	Jeremiah 19a. Informant's Name/Re	ationship (7	ives Brint)		Arthu		/Ctrant		Doret	al Route Numbe		laine		
Ma	0 0 0		Tara Rogers	ationship (7		aught		-				arkvill				21234
ē,	of Health of Health fitem 27		20a. Method of Disposition			20	Ob. Place of Disp	osition (Nan	ne of	a) l	C	Date	20c. Loc	ation - City	or Town, St	ate
E	Pages nent of I int: If its ury or o		y□Burial 2 □ Crem 4 □ Donation 5 □ Ot			State	King Me	_		, [1-13	8-06	Ra	ndall:	stown	Md.
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral S	ervice Licen	See	-	2	2. Name an	d Addres	s of Facilit	ty	Ba	ltim	ore, N	1d. 2	1202
-	20529		23a. Part1. Enter the disea	adi	8 U)au	نسعه	March						North	1	ximate
	Physician /Medical Examiner	shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to infriediat cause. Enter Underlying Cause (Disease or injury that infitated events	lettes							Interv	al Between I and Death					
ox 68760,	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	n/Medical Examiner	resulting in death) Last IF FEMALE: 23b. Was decedent pregna		d23c. If yes, ou			⊒Ectopic pr	0000000				2	3d. Date of	delivery	
P.O. B	that the deal	Physician/Med	in the past 12 months 1 □ Yes 2 ☑ No 9 □ Unknown	?		nant at time		Other (sp						Month	Day	Year
ords, F	w requires tha been signed should be de	þ	Part II. Other significant co	onditions co	entributing to d	death but no	t resulting in the t	underlying ca	ause give	n in Part I		23e. Did to	_	e contribute		e of death?
I Records,	ysician: The law r is certificate has be director, page 2 sh	Completed										24a. Was autop perfo 1 Yes	rmed?	24b. Were prior 1 death 1 \(\sum Y\)	o completio	dings available in of cause of
Vital	ician: Th certificate ector, pag	Be	25. Was case referred to mexaminer?		t to a = it at.				7		of Death	Check only o	ne)		_/\	
of	Physician: this certificanal director, participal d	2	1 ☐ Yes 2 No 27. Manner of Death				2 ER/Outpatie			4 🗆 140		me 5 Resid			pecify)	
	ding After fune	달	1 Matural 5 □ I	ending nvestigation	(Mon	of Injury oth, Day Yea	ar) Injury	M Z	8c. Injury Work	at ? ′es 2□		28d. Desćribe h	iow injury	occurred		
Ö	f or Attending after death. Director: After I in by the fune	Certification:	3 ☐ Suicide 6 ☐ 0	Could not be determined	286. Place	e of Injury ling, etc. (Sp	At home, farm, st pecify)					28f. Location (S City or Tou	Street and vn, State)	Number or	Rural Route	Number.
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier 1 Ce	rtifying Phy dical Exam	liner: On the b	e best of my pasis of examiner stated.	knowledge, dea mination and/or in	th occurred avestigation,	at the tim in my op	e, date an inion, dea	d place,	and due to the o	cause(s) a	and manner place, and c	as stated. lue to the ca	use(s)
	To the within 2 To the c-mple	Me	29b. Signature and title of o	ertifier				290	. License	number			29d. Date	signed (Mo	nth, Day, Y	ear)
	Λ		marion	ente	I ni	iran	Mus		Da S	1099	3		1/11	106		
-	4		30. Name and address of p	erson who d					11:40		Cons					
			21 Data filed (M:= 15 C	33.50	54.	CAL!	15001	+ 1	111	- 3	131	8				
	Sta Registr		31. Data filed (Month, Day, JAN 1	2 2008		Registrar's S	oignature	Car.								

Registrar

31. Date filed (Month, Day, Year) 2006



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sherry Barrett State of Maryland / Department of Health and Mental Hygiege 06 - 0226Reg. No. Certificate of Death **KG** 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Sherry Lee Barrett 9. 2006 4:00 A January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a University Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan 10, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 🎖 🗀 F 219-76-4420 37 Director Maryland Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 7 is marked other than "natural", or Itama 23e or 28e-1 shov traumatic avant, the Madical Examinar must be notified at 1 ☐ Yes 2 🗓 No Conowingo Directo Maryland Ceci1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 126 Conowingo Lake Road 21918 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 Specify: Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be ind Mental William G. Benjamin Gail Shuler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Heelth i Richard M. Barrett, Husband 36 Virginia Avenue North East, Maryland 21901 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itee
any Injury or oth 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 01/12/06 Baltimore, Maryland 22. Name and Address of Facility
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service License Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Gunshot Wound to Head Contac Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. ed by the e 1 ☐ Yes 2 ☐ No 9 X Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of do h?

1 Yes 2 □ No 24a. Was an page 2 s 1XYes 2□No certificete : After this certifice funeral director, j 25. Was case referred to medical Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Division Injury 1 Natural 5 Pending unknown Subject 9-06 2 Z/No Shot death. investigation 2 Accident 28! Location (Street and Number or Rural Route Number, City or Town, State) 126 Conswergo Lock Ad the Diractor: 6 Could not be determined 3 X Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etg. (Specify) Place of the building, etc. (Specify) filled in by 6 onowengo MD within 24 hours a

To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 🛱 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. January 10, 2006 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland

State

Registrar

CAROLHAZ

JAN 1 2 2006

31. Date filed (Month, Day, Year)

LAN

Ma

32. Registrar's Signature

sales

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Regis Certificate of Death Reg. No 2 Date of Death 3. Time of Death Month | **Physician** 6:25 AM /Medical 4b. (ity) Town, or Location of Death 4c. County of Deal Examiner Baltimore esville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 M 2 □ F Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director and Number 10f. Zip Code 10g. Citizen of What Country? 21208 Funeral 0 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed For d Forces? 'es 2 □ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give Rind of work done during life De NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry post of working (Specify only highest grade completed) Elementary Secondary (0-12) College (1-4or 5+) Middle Last) (First, Middle, Maideo Be 20b. Place of Disposition cemetery, crematory Method of Disposition Department of H Important: If ite any injury or ot once. Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service lutown, and allas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** Lun /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospitel or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? None Kyowy 1 ☐ Yes 2 ☐ No 3 Probably 4 Priknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient Jo 1 🗌 Yes 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier icai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1112106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste #340 Owings in. 110 md 10 Driva Crossroads Howard M.D. 23 Risutz 31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JAN12

2006

32. gistrar's Signature

4.			1 - For State Registrar	State of Maryland		rtment of Health and tificate of Death		iene g. No.	00447
	Physici	an	Decedent's Name (First, Middle, Last Gregory Ball)			2. Date of Deat Month		3. Time of Death
	/Medic Examir	al	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of Dea	January	3, 2006	1:18 A M
	LXamiii	iei	University of Mar		uma	Baltimore		les desiry di Bodin	
D.	Funeral Director		5. Social Security Number 6. Se 220 94 4464 X Usual Residence of Decedent	x	Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		Year) 9. Birth Cou	place (State or Foreign ntry)
	yland		10a. State 10b. County MD		Town or Lo				10d. Inside City Limits
	he Ma 28a-f s	Director	10e, Street and Number	Balt	timor				XXYes 2 □ No
	N with t		1357 Carroll St	•		10f. Zip Code 21230		Og. Citizen of What Cou	ntry?
980	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "natural", or items 23s or 28s-f show event, its Medical Examinar must be notified at	by Funeral	11. Maritaf Status 1X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ XXvo If Yes, Give Year or Dates:	1	Vas Decedent of Hispanic Origin? (\$2 Yes, specify Cuban, Mexican, Puer		14. Race - Ameri Black, White, Specify: Bla	etc.
Maryland 21215-0036	within 72 horane. then "nature the Medical E	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) Coflege (1-4or 5+)	(Give I life. [ent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	16b. Kind of Business/In	
land 2	Hygi other	To Be Co	11th 17. Father's Name (First, Middle, Last) Gregory Ball, Sr	•	Lab	orer 18. Mother's Na Agnes W	me (First, Middle, M	ome Impro Maiden Sumame)	· V •
, Mary	permit. Pages i and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic ev		19a. Informant's Name/Relationship (T) Agnes Wilkins			g Address (Street and Number or R Carroll St. E			Code)
Baltimore,	Pages 1 ament of He sant: if item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	d Ri	ation (Name of latory or other place) dge Cem. 1-10	0-06 B	20c. Location - City or To alto. Co.	
l Balt	permit. Depart Import any in		21. Signature of Funeral Service Licens	Chart	2	Name and Address of Facility We 007 Eastern Av	enue Ba	lto. MD 2	
68760,	Hilicate be executed / Medical Examiner as the burial-Itansit as the burial-Itansit	edical Examiner	23a. Part1. Enter the disease, of ompostock, or heart failure. Lixt only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		GUP nce of):	VSHOT WOVYD		St.	Approximate Interval Between Onset and Death
P.O. Box 68	death cer e ettendir id for use	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death	ath 3 🗆	Ectopic pregnancy Other (specify)		23d. Date of defive Month	ery Day Year
Ś	requires that the een signed by th hould be detache	۵	Part fl. Other significant conditions col	ntributing to death but not resultin	ng in the un	derlying cause given in Part I.		acco use contribute to the	ne cause of death?
Division of Vital Record	The law received has been page 2 sho	Completed					24a. Was an autopsy perform	ed? prior to co.	psy findings available mpletion of cause of
Xit	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	fospital:		04	ath Check only one		
ion of	To the Hospitel or Attanding Physician: The law within 24 hours effer death. To the Funerel Director: Affer this certificete has completely filled in by the funeral director, page 2	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a Date of Injury 28	b. Time of Injury	28c. fnjury at Work?	28d. Describe how		OT
Divis	itel or Atta us efter de rel Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☑ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	a, farm, stre	et, factory, office	165 CAREL	1 ST, BALTIM	ORE, MD
	Hospitel 24 hours e Funerel I letely filled	Medical	29a. Certifier 1 Certifying Phy. (Check only one) 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time, date and place estigation, in my opinion, death occu	e, and due to the cau irred at the time, da	use(s) and manner as si te and place, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License number	29	d. Date signed (Month,	Day, Year)
/			· Well			OCME	J	anuary 3, 2	006
(J)		30. Name and address of person who co		Ba) (Type, F	rint) 111 Penn Street	, Baltimo:	re, Marylan	d 21201
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 2 20	32. Rehistrar's Signature	k As				

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	partment of F Prtificate of	Health and M <i>Death</i>	lental Hy	giene (16	00448
	Physici	an-	Decedent's Name (First, Middle, La LOUIC					2. Date of De Month	_	Year	3. Time of Death
	/Medic	al	LOUIS 4a. Facility Name (If not institution, giv		verati	4h City Toyan o	or Location of Death	1 1	0 2006	ntv of Death	7:55p м
	Examin	ier	Manor Care Nursing	•		Towson	Cocation of Death			more	
	Funeral Director		5. Social Security Number 6. S 216-20-4719		(In yrs. last birthda 9 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 3-20-1	th 927	Cou	place (State or Foreign http://land
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				1	10d. Inside City Limits
	Mary s-f sho	to	Md.		Baltimore	!					1 X Yes 2 □ No
	or 284	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
	s 23a	ral	4306 Anntana Ave.	1		2120			USA		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Indoorbar than "natural", or Itams 23a or 28a-f show evant, I're Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Wes 2 No If Yes, Give Year or Dates:		Was Decedent of F If Yes, specify Cub:	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Spec	lace - Americ lack, White, cify: Whi	etc.
5-0	72 ho 'natur	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Giv	edent's Usual Occup	during most of worki	ina	16b. Kind of	Business/In	dustry
121	within ene. than *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) lite.	DO NOT use retired	d)	9	Conat	a loti ola	
d 2	il Hygie othar vant,	a l	17. Father's Name (First, Middle, Last))	11	on Worker	18. Mother's Name	e (First, Middle,		ruction ame)	
/lan	2 should be and Mental Is marked c	To B	Emilio Beverat	i			Mary M	Marani			
lar	and and ls m		19a. Informant's Name/Relationship (Type, Print)			and Number or Rum			m, State, Zip	Code)
	1 and 1 Health Brn 27 thar tr		Darlene A. Prell 20a. Method of Disposition		8723 20b. Place of Disp		1 Rd. Perry	Hall, Md		- Oh T	Children
Baltimore,	Pa ner iry		1 🕅 Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	y)	Gardens	ematory or other plac of Faith	1-14	-2006		timore	
Bal	permit. Departr Importa any inje		21. Signature of Funeral Service Licer Gary R. DiGiovanni	1. 11 1.	Eovanni	22. Name and Addre 5305 Harfo	ss of Facility Leon ord Rd. Balt	nard J. R Jimore, M	uck Fune d. 2121	ral Hom 4	æ
	Prysician /Medical Examiner	niner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	aDue to (or as a	consequence of):	nter the mode of dyir	ng, such as cardiac c	or respiratory a	rrest,)	Approximate Interval Between Onset and Death
68760, <	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	that initiated events 'resulting in death) Last	cDue to (or as a	consequence of):						
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ords, P	equires that en signed b	ed by P	Part II. Other significant conditions of Dia Getes mel			underlying cause giv	en in Part I.	The same of the sa	obacco use co res 2 🗆 No		ne cause of death? ably 4 Unknown
of Vital Records,	The tay ate has bage 2	Completed by								prior to condeath?	psy findings available mpletion of cause of
Vit.	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death				
of	> 0 0	7. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Injun	y at 2	ne 5 Resid			/)
ion	Attending or death. actor: After by the fune	atlo	1 ►Natural 5 □ Pending 2 □ Accident investigation	(Month, Day)	Year) Injury	Wor	k? Yes 2 □ No				
Division	tal or Atters a safter de al Diracto	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, s (Specify)	treet, factory, office	2	28f. Location (S City or Tox	Street and Nun vn, State)	nber or Rura	l Route Number,
	To the Hospital or Attending Phwithin 24 hours atter death. To tha Funaral Diractor: After th completely filled in by the funeral	edical	one)	ysician: To the best of niner: On the basis of e and manner state	xamination and/or i	th occurred at the tin nvestigation, in my o	ne, date and place, a pinion, death occurre	and due to the o ed at the time, o	cause(s) and r date and place	nanner as st	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	/ , .		29c. License			29d. Date sign		
F			pow ida	of MI			1199		Jan,	11, 2	1006
	12		30. Name and address of person who	completed cause of dea	by The Chair	rles ST.	Suite 203,	Towso	n, mi) 217	204
	Sta Registr	-	31. Date filed (Month, Day, Year) JAN 1 2 2	32. Registrar	s signature	meti					

			1 - For State Registrar		larylar			nt of He		nd Mental Hy	Reg. No	UUD	004	49
	Physici	an	Decedent's Name (First, Middle, La ATATOM TELEVISION	•	TIZ TION	D				2. Date of D	Day	y Year	3. Time o	
	/Media		AVALON EVANS 4a. Facility Name (If not institution, given		CKFOR	ע	Ah Cihi	Town or	Location of [2006 County of De	8:00	A. M
	Examir	ier	COLLINGTON NURSI		,				LVILLE		1		GEORGE '	S
*	Funeral Director		5. Social Security Number 6. S 554-22-3609	Sex 7. A 1 □ M 2 X □ F	ge (In yrs. 82	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hours	Hrs. 8. Date of B Min. (Month, D JULY 2	irth lay, Year)	9. B	irthplace (State Country)	or Foreign
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	ocation						10d. Inside (
	hours after death with the Maryland turel', or Itams 23a or 28s-1 show al Exantherr turi be notified at	ō		GEORGE'S		ITCHEL		ıΕ						2X No
	288-	Director	10e. Street and Number				10f. Zip	o Code			10g. Cit	izen of What C	Country?	
	th with		10450 LOTTSFORD	ROAD				20716	5		U.	S.A.		
	dea dea	Funeral	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.	Was Dece	dent of His	panic Origin	n? (Specify Yes or N Puerto Rican, etc.)		14. Race - Arr		
36	or it	by Fu	1 Never Married 2 🕅 Married	1 ☐ Yes 2√2 If Yes, Give				2[X] No		oono moan, etc.)		Black, Wh	ite, etc. HITE	
8	72 hours after dea "naturel", or itams		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:		16a. Dece					101 10			
15	l within 72 ho liene. r than "natur the Medical	piet	(Specify only highest gra	ade completed)		(Give	kind of wo	ork done di se retired)	iring most o	f working		ind of Busines S • FE		
212		Completed	Elementary/Secondary (0-12)	College (1-4or 2	5+)		SECI	RETAR	Y		GO7	VERNMEN	T	
Maryland 21215-0036	al Hy	Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle	, Maiden	Sumame)		
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	1 and Healt		WILLIAM C. BICKFO	JRD / HUSE	20b. F	lace of Dispo	sition (Nai	me of		D, MITCHE		LLE, MA		20716
nor	0 0	1	1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			semetery, crer	natory or c	other place	1					
Baltimore,	글릭판군 .		21. Signature of Funeral Service Lice		HUI	NTT CRI			1/ of Facility	11/2006			ARYLAND	
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each I	d the deat							HILL DIN	Approxima Interval Be	te
	Physician		Immediate Cause (Final disease or condition	Jm.	11	cell	C	ar c	100	~~ _			Onset and	
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):				ney -	2 = 2	2.30	3 00	
		<u>-</u>	Sequentially list conditions if any, leading to immediate	b. Due to (or as			وسماره		f	.010	11 6001	.001	9/1	. 47
V	uted 1 Insit	Examiner	Cause (Disease or injury	300 10 (01 00	a conseq	481100 017.								
Ġ	exection and ital-tra	Exa	that initiated events resulting in death) Last	c. Due to (or as	a conseq	uence of):								
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	ing ph	Med	IF FEMALE:					77			-	-	•	
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Feta	Ideath 3□	Ectopic pr				2	23d. Date of de Month		Year
P.0.	Attending Physicien: The law requires that the death certific refeath. refeath. sctor: After this certificate has been signed by the attending p.	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 □ Pregnant a 9 □ Unknown	t time of d	eath 5	Other (sp	pecify)				WOTE	Day	1 641
۳.	that i		Part II. Other significant conditions of	ontributing to death b	out not resi	ulting in the ur	nderlying c	ause giver	in Part I.	23e. Did	tobacco u	se contribute t	o the cause of	death?
rds,	n sign	d by	- fulmoner	7 Fib	100	-				10	Yes 2]No 3∏P	robably 4 🗌	Unknown
ပ္ပ	s bee	piete								24a. Was	an	24b. Were a	utopsy findings	available
Division of Vital Record	The I	Completed									psy ormed? 2 No	prior to death?	completion of o s 2 □ No	cause of
ita	sien: artifica ctor, I	Be	25. Was case referred to medical examiner?						26. Place of	Death (Check only		1016.	2 2 140	
5	hysic this co	၉	1 ☐ Yes 2 ☐ No			ER/Outpatien			4 M NUTSIT	ng Home 5 ☐ Res			ecify)	
<u> </u>	ling P	lon:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		8c. Injury a Work?		28d. Describe	how injury	y occurred		
<u>S</u>	death death ctor: the	Icat	2 Accident investigation 3 Suicide 6 Could not b		iun(- At ho	me farm etre	M		es 2 □No	28f. Location /	Ctrant	d \$6	ural Route Nun	
<u>≥</u>	al or a after i Dire	Certification:	4 ☐ Homicide determined	building, et	c. (Specify	()	ser, ractory	y, onice		City or To	wn, State))	urai Houte ivun	nber,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysicien: To the best niner: On the basis o and manner st	f examinal	wledge, death tion and/or inv	occurred estigation	at the time , in my opir	, date and p nion, death o	lace, and due to the occurred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s	s)
	Totl withi Comp	Σ	29b. Signature and title of certifier		A A			. License i		3	29d. Date	e signed (Mon	th, Day, Year)	
,			Demily 4		20			120	07	1	11	0/00		
	5		30. Name and address of person who	completed cause of c	leath (Item	23a) (Type, I	Print)	رورب	Live	P (. = .	50-1	Len	hem 1	no
K)	Sta	te	31. Date filed (Month, Day, Year)	32. P gistr	ar's Signa	ture	1 1					2	1706	
	Registr		JAN 1 2 2	006	we.	A. A	sauce.							

			1 - For State Registrar	State of M	Maryland / Dep <i>Ce</i>		of Health and of Death		gi éne	6 00)450
+6	Physici	an	1. Decedent's Name (First, Middle, La	•	יות אם			2. Date of De Month	Day	Year	3. Time of Death
P	/Media	tal	DEBORAH 4a. Facility Name (If not institution, giv	RAE	BARE	4b. City. Toy	vn, or Location of Deal	JANUA]	RY 10	2006	1:45 ^M
	Examir	ier	1304 HARLING	COURT	,	,	AIR			FORD	
	Funeral	- 50	Social Security Number 6. S	ex 7. A	Age (In yrs. last birthday)		ear II Under 24 Hrs ays Hours Min.		th Y. Year -		e (State or Foreign
×.	Director		213 60 5887 Usual Residence of Decedent	III PLA	53 Yrs.			03,13	/1952	MARYI	JAND
	yland		10a. State 10b. County	**************************************	10c. City, Town or Lo						Inside City Limits
	Ba-f el	Director	MD BALTI	MORE	ROSEDAL						1 ☐ Yes 2 ☐ No
	or death with the Marylar tems 23s or 28s-f show er must be netitied at		10e. Street and Number 8021 EDGEWATE	R AVENUE		10f. Zip Co	de I 237		10g. Citizen of US.		?
9036	72 hours after daath with the Maryland naturel', or Items 23a or 28a-f ehow Jisal Ezanif at must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 X II Yes, Give Year or Dates] No	Was Decedent If Yes, specify	ol Hispanic Origin? (S Cuban, Mexican, Puer No <i>Specify:</i>	Specify Yes or No to Rican, etc.)	14. Rad Bla Specif	ce - American ck, White, etc. WHIT	
1215-	within 72 hane. then *natu	Completed	15. Decedent's E. (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4o	(Give	dent's Usual O kind of work d DO NOT use re AN OFI	one during most of wo etired)	rking	16b. Kind of B	usiness/Indus	,
Maryland 21215-0036	be filed ital Hygi od other event, I	To Be Co	17. Father's Name (First, Middle, Last RAYMOND WA)				18. Mother's Na	me (First, Middle,	Maiden Surnar BAKER	пө)	, , , , , , , , , , , , , , , , , , , ,
	d 2 sh th and 7 ls m treum		19a. Informant's Name/Relationship (-	reet and Number or R		*	-	ode) 21237
Baltimore,	Pages 1 and ment of Heati ant: If item 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speed)	Removal from Stat	e METRO	osition (Name of matory or other CREMAT	r place)	3/06	20c. Location BALTII		
Balt	permit. Pag Depertment Important: I any njury o		21. Signature of Euroaral Service Lices	ns/e			ddress of Facility CV HESACO AV		SEDALE FIMORE		
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. MM	m hem	ter the mode of	dying, such as cardia	c or respiratory ai	rest,	Int	pproximate derval Between deset and Death
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, 0928	cate be executed physician and the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Mil	s a consequence of):	2				3	44!
O. Box 6	that the death certifica ed by tha attending ph detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregn □ Other (specif				ite of delivery onth Day	y Year
rds, P.	sign d be	ρ	Part II. Other significant conditions of	ontributing to death	but not resulting in the u	Inderlying caus	e given in Part I.	23e. Did to	obacco use con res 2 No	tribute to the c	
of Vital Record	The law ate has b page 2 si	Completed	<i>Y</i>					24a. Was autop perfo 1 🗆 Yes	rmed?	Were autopsy prior to comple death? 1 Yes 2	findings available etion of cause of
on of Vit	Attending Physician: 1 r death. ector: After this certifical by the funeral director, p	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending 2 Accident investigatio	Hospital: 1 Inpa	jury 28b. Time o		Othor	ath (Check only of dome 5 Residence of 28d. Describe h		ioi (Spocity)	AUTHERS HOME
Division	= # # = =	Certification:	3 Suicide 6 Could not b	e 28e. Place of I	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, of	fice	281. Location (S City or Tox	Street and Numb vn, State)	per or Rural Ro	oute Number,
	To the Hospital or At within 24 hours after of To the Funeral Directompletaly filled in by	edicai	29a. Certifier (Check only one) Certifying Ph	nysician: To the bes niner: On the basis and manner:	st of my knowledge, deal of examination and/or in stated.	vestigation, in	my opinion, death occi	a, and due to the urred at the time,	cause(s) and made and place,	anner as stated and due to the	d. eause(s)
	W T W T	×	29b. Signature and title of certifier	our			48/60		29d. Date signe	2000 2000	v, Year)
مس	10		30. Name and address of person who PETL HAUCHE	e MD 2	death (Item 23a) (Type, 2 SOUTH G	Print) REEN	E STREET	BALTI	MORE,	MD 212	0/
	Sta Registr	_	31. Date filed (Month, Day, Year)	37	strar's Signature	Cont.			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Canning January 6. 2006 8:00p 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Dulaney Valley

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Stella Maris Hospice Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 ☐ M 2 ☑ F 212-30-1335 74 5, 1931 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 ☐ No Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3506 Clarenell Road 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas F. Canning (Son) 2127 Hampton Ct., Fallston, MD. 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 1/10/06 Baltimroe, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a Part Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)

Pnysician /Medical **Examiner**

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attending physicien

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To the Hospitel of within 24 hours at To the Funerel D

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records.

or Attending Physician:

permit. Peges
Department of
Important: If It

Physician

/Medical

Examiner

Funeral

Director

28a-f ehow

or Items 23a

Peges 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Item

Baltimore, Maryland 21215-0036

avent, the Medical Examiner must be notified at

Directo

Funeral

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Completed

Be ٩ Dorothy

10a. State

11. Marital Status

12

Physician/Medical þ Be Completed Certification: To

Examiner IF FEMALE: 25. Was case referred to medical examiner? 1 Yes 27. Manner of Death 1 Natural 2 Accident 3 Suicide

Sequentially list conditions, any, backing a immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 No

31. Date filed (Month, Day, Year)

4 Homicide

5 Pending

investigation 6 Could not be determined

1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

Year

24a. Was an 1□ Yes 26. Place of Death | Check on v one

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

4 Nursing Home 5 Residence 6 Other (Specify) HOS DIC.C.

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

3 DOA

29b. Signature and title

2 2006

Other:

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

32. Registrar's Signature

1 Inpatient 2 ER/Outpatient

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

				artment of Health and Mental Hygie rtificate of Death	006 00452
	Physici /Medic		Decedent's Name (First, Middle, Last) VERNON EDWARD CA	SHMAN 2. Date of Death Month JAN 8	Day Year 3. Time of Death 4:30 P M
	Examin		4a. Fecility Name (If not institution, give street and number) 1230 EMERALD RIDGE DR. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death WESTMINSTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth	4c. County of Death CARROLL 9. Birtholace (State or Foreign
	Director		214-16-1253	Months Days Hours Min. (Month, Day, Y	922 MARYLAND
	th the Marylar or 28s-f show e notified at	Director	10a. State 10b. County 10c. City, Town or It MD CARROLL WEST 10e. Street and Number 10c. City, Town or It	MINSTER	10d. Inside City Limits 1 ☐ Yes 2 🖔 No D. Citizen of What Country?
15-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "neturel; or items 23e or 28e-f show or other treumatic event, the Medical Examinal must be notified at	leted by Funeral Director	1 Never Married 2 Married 1 Myes 2 No If Yes, Give 15. Decedent's Education (Specify only highest grade completed)	21158 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify: Ident's Usual Occupation a kind of work done during most of working DO NOT use retired)	USA 14. Race - American Indian, Black, White, etc. Specify: WHITE bb. Kind of Business/Industry
and 2121	2 should be filed within and Mental Hygiene. is marked other than "eumatic event, the Mar	Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) 8 17. Father's Name (First, Middle, Last) CLARENCE EDWARD CAS	TROUBLE SHOOTER UT	
Maryland	12 should n and Men is marke reumatic	은	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Rural Route Number, C	City or Town, State, Zip Code)
Baltimore, №	permit. Pages 1 and 2 Department of Health Importent: if item 27 any injury or other tra 20029.		20a. Method of Disposition 1 \(\mathbb{N} \) Burial 2 \(\mathbb{C} \) Cremation 3 \(\mathbb{R} \) Removal from State 4 \(\mathbb{D} \) Donation 5 \(\mathbb{D} \) the (Specify) 21 Signature of Fine 1 Service Licensee	EMERALD RIDGE DR., WES osition (Name of matory or other place) N MEM.GARDENS 1/12/06 In the place of the pla	c. Location - City or Town, State FINKSBURG, MD. FUNERAL HOME
8760,	The law requires that the death certificate be executed The law requires that the attending physician and in a label to a specific and in a label to a specific and in a label to a specific and in a label to a specific and in a label to a specific and in a label to label to a label to a label to a label to a label to a label to	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ASPIRATION PN: Due to (or as a consequence of): ASPIRATION PN: Due to (or as a consequence of):		Approximate Interval Between Onset and Death YEARS 2 MONTHS 2-3 DAYS
O. Box 6	that the death certifice ed by the attending pt detached for use as t	Physician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
Δ.	w requires that the bean signed by should be detact	by	Part II. Other significant conditions contributing to death but not resulting in the		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 ★ Unknown
of Vital Records,		e Completed	25. Was case referred to medical	24a. Was an autopsy performed 1 ☐ Yes ② 26. Place of Death (Check only one)	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Division of Vi	ding Phys h. After this funeral dii	Certification; To B	examiner? 1 Yes 2 No 1 Inpatient 2 EP/Outpatie 27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be	ont 3 DOA Other: 4 Nursing Home 5 AResidence of 28c. Injury at Work? M 1 Yes 2 No	
Οİ	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the		building, etc. (Specify) 29a. Certifier Certifying Physicien: To the best of my knowledge, dea	City or Town, S	State) se(s) and manner as stated.
)	To the Hi within 24 To the Fi complete	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or is and manner stated. 29b. Signature and title of certifier William Manner	29c. License number 29d.	Date signed (Month, Day, Year)
XI	Sta Registr	-	30. Name and address of person who completed cause of death (Item 23a) (Type KATHY WEISHAAR MD 295 STONER 31. Date filed (Month, Day, Year) JAN 1 2 2006	AVE. #307, WESTMINSTER	, MD. 21157

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland /	-	artmen rtificate					giene	006	004	53
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	/Medic		4a. Facility Name (If not institution, giv		2176		4b. City,	Town, or	Location of		MAZ	40	County of Dea		PM
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	Funeral		5. Social Security Number 6. S		(In yrs. last		If Under Months		If Under		. Date of Birth (Month, Day	Year)	9. Bir	thplace (State	or Foreign unk
	Director		Usual Residence of Decedent	X	64	Yrs.				(19-			
	yland how		10a. State 10b. County		10c. City, To	own or Lo	cation				<u>-</u>			10d. Inside C	ity Limits
	Ba-fs	ctor	MD Howard			E11	icott	Cit	У					1 TYes	2 No
	with the	Funeral Director	10e. Street and Number	Dood			10f. Zip	Code	,	210/2	1	10g. Cit	izen of What Co	ountry?	
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	and 2 sho lealth and m 27 Is m har traum		Howard County Gen										r Town, State, 2	Lip Code)	
Baltimore,	- I 0 =	İ	20a. Method of Disposition 1 Burial 2 Cremation 3	•	20b. Place	of Dispo	sition (Nam natory or of	ne of	-	Date	ia, MD	20c. Lo	Cation - City or	Town, State	
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	/Medical		disease or condition resulting in death)	Due to (or as a			,	1 1	1401	11011	14				
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9	death certifica attending ph	/Med	IF FEMALE:	23c. If yes, outcome of	of pregnancy										
Вох	death atten d for u	ician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth : 4 ☐ Pregnant at	2 Fetal dea		Ectopic pre						23d. Date of del Month	*	Year
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ital	an: T	a	25. Was case referred to medical						26. Place	of Death C	1□ Yes 2 Check on on	2 Z No	1 Tes	2 1 0	
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Division of	or Attending Physician: The I after death. Diractor: After this certificate ha in by the funeral director, page'	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home,	farm, str			62 Z 🗆 L	-	Location (St	reet an	d Number or Ru	ral Route Num	iber.
Ö	tal or A	Certification;	4 Homicide determined	building, etc	. (Specify)						City or Town	n, State)		
	Hospi 4 hou Funar ely fill	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best o niner: On the basis of and manner state	examination a	lge, death and/or in	occurred a restigation,	at the time in my opi	e, date and nion, deat	d place, and h occurred :	I due to the ca at the time, da	ause(s) ate and	and manner as place, and due	stated. to the cause(s	3)
	To tha within 2 To tha complet	Σ	29b. Signature and title of certifier					License					e signed (Month		,
•			30 Name and address of assess the	completed cause of de	ath /lton 00-	a) /T	Drint'	306	41	2	(0)	jan	uary o	2001)
			30. Name and address of person who Rabapa	This 201-1	09 BC	ACK	River	Ne	ck	Koad	Bal	Inn	nove M	ceryland	21221
:4	Sta Registra	te	31. Date filed (Month, Day, Year) JAN 1 2 2006	32. Registra	r's Signature	barl	20								

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П	Physici	an	1. Decedent's Name (First, Middle, Las	st)		4° 11 A -2			2. Date of Month		Day Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give	e street and number)		CHAG	4b. City, Town,	or Location	JANU:		tc. County of Dea	
Н	Exami	101	NORTHWEST	HOSPI	TAL			OALLS.			BALTIN	
	Funeral Director		5. Social Security Number 6. Social Security Number 1 002-03-6779 Usual Residence of Decedent	ex 7. Ag □M 2☐F	ge (In yrs. las 92	st birthday) Yrs.	If Under 1 Yea Months Day:		Min. (Month	Birth Day, Yea	9. Bir	thplace (State or Foreign ountry) Maine
	yland Jow		10a. State 10b. County		10c. City,	Town or Loc	ation		·			10d. Inside City Limits
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	with th	Funeral Director	10e. Street and Number				10f. Zip Code			10g. (Citizen of What Co	ountry?
	eath v	erai	313 Bond Ave.	12. Was Decedent	Ever in U.S.	13 W	1	Hispanic Ori	gin? (Specify Ves o	· No-	14. Race - Ame	SA
036	ours after d ral', or Item Events et	by	1 Never Married 2 Married 3 Widowed 4 Optivorced	Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	?	lf	Yes, specify Cu		gin? (Specify Yes or , Puerto Rican, etc.	140-	Specify: W	te, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Eventral termital termital and ance.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or !	5+)	(Give k life. D	ent's Usual Occi ind of work don O NOT use retir	e during mos red)		Ma	Kind of Business nufactur ectronic	ing
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altimore, N	Pages 1 and nent of Health ant: If Item 27 ury or other tr		Emma Wiess/daug 20a. Method of Disposition 1 Burial 2 Cremation 3		20b. Plac	313 E ce of Dispos netery, crema	Bond Aviition (Name of atory or other pl	ve., R	eisterstov Date	yn, 1 20c.	AD 21136 Location - City or	Town, State
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Ba	permit. Departr Importa any inji		21. Signature of Funeral Service Lice. Michael J Ela	gle		Lei	Mame and Addi	uneral	Home of	Dula	ney Val	ley, Inc.
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that caused	d the death. ne.	Do not enter	r the mode of dy	ring, such as	cardiac or respirator	y arrest,	, WID 21	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as	a conseque							days
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on	Attending Physician: r death. ector: After this certific. by the funeral director.	ation	1 Natural 5 ☐ Pending investigation	(Month, Da	y Year)	Injury	Wo	ork?]Yes 2.⊟1		30 11011 1111	ary occurred	
Division of		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc		e, farm, stree	et, factory, office		28f. Locatio City or	n (Street a Town, Sta	and Number or Ru te)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier j⊠ Certifying Phy (Check only one) (Check only one)	ysician: To the best liner: On the basis of and manner sta	f examination	edge, death on and/or inve	occurred at the t stigation, in my	time, date and opinion, deat	d place, and due to the time	he cause(ne, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c. Licen	ise number		29d. D	ate signed (Month	h, Day, Year)
	~		Ourtson	M.D.				005	7736	To	ennon	10 2006
2			30. Name and address of person who o				,	t- 50. 4		V	LE COUR	27 6000
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signatur	RTHWE	3/	tospit,	AL 54	01 6	,	-1 200
	Registr	ar	JAN 1 9 20	06	J. Jr.	A STATE OF THE PARTY OF THE PAR	W.					

DHMH 17 Rev 1/2001

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			Registrar 1. Decedent's Name (First, Middle, Las	5 <u>)</u>	Contino	0, 00	, au,	2. Date of D		*	3. Time of Death	_
	Physicia /Medic		Vanessa	Dorsey				January	7 6	2006	0138 M	
	Examin		4a. Fecility Name (If not institution, give		4b. C	ity, Town, or Lo			4c.	. County of Dea	th	
2			Union Memorial H 5. Social Security Number 6. S		last birthday) If Ur	Baltim Ider 1 Year	Ore Under 24 Hrs.	8. Date of B	irth	9. Bir	thplace (State or Foreign	<i>n</i>
1089	Funeral Director			□M 2×2F	Yrs. Mont	hs Days F	Hours Min.	Youth 0	3 - E	58 M	aryland	Š
	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-1 ehow for Medical Examinar must be notified at	tor	10a. State 10b. County	10c. Cit	ty, Town or Location	nre)					10d. Inside City Limits 1	
	ours after death with the Marylar elf, or Items 23e or 28e-1 ehow Exercites must be rootified at	Director	10e. Street and Number	1 Stone +	10f.	Zip Code	18		10g. Cit	USA	ountry?	
	oms 2:	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was Do	ecedent of Hispa specify Cuban, N	anic Origin? (Sp Mexican, Puerto	pecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whi		
036	urs afte	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ∰ Oo If Yes, Give Year or Dates:	1 □ Ye	s 2 No S	Specify:			Specify:	lack	
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Decedent's l	Jsual Occupation work done during Tuse retired)	n ng most of work	king	16b. K	ind of Business	/Industry	
2121	d within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	De	DA 45	tic		1	Priv	rate)	
Maryland 21215-0036	be fill H and of the other of t	Be	17. Father's Name (First, Middle, Last)	1 htk		18	. Mother's Nam	e (First, Middle	e, Maiden	Sumame)		
IZ Se	d 2 should be th and Mental 7 is marked o	ှ	19a, Informant's Name/Relationship (Type, Print) (SON)	19b. Mailing Add	ress (Street and	Number or Rui	ral Route Numi	ber, City o	or Town, State,	Zip Code)	
			Roland M. I	procen JR	: 1834		Uh St	reat				
altimore,	T T T		20a Method of Disposition Surial 2 Cremation 3	• (Place of Disposition cemetery, crematory	(Name of or other place)		Date	20c. Lo	ocation - City or	Town, State	
Ē			4 Donation 5 Other (Specification of Funeral Service Licer		-· LION (emeter	y I I	2/06	Ba	101	MD CO A	$\frac{1}{2}$
Ba	permit. Departrimportump		130 C/7+	~ MO136	3 Van	ghu C	ACT EL	i. T	018	MO	21212	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	th. Do not enter the	mode of dying, s	such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death	
- My	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cocaine and Na		ication					Criser and Death	_
2	/Medical Examiner			Due to (or as a consec	quence of):							
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):							
	and and I-transit	xamin	Cause (Disease or injury that initiated events resulting in death) Last	c	quence of):							
760,	sicien buria	alE		d	,							
.89	tificate ng phy as the	ledic		<u> </u>								_
J. Box 68760,	The law requires that the death certificate be exate hes been signed by the ettending physicien page 2 should be detached for use as the buria	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	aldeath 3□Ectop	ic pregnancy (specify)				23d. Date of de Month	olivery Day Year	
9.	res that the de signed by the e be detached i		Part II. Other significant conditions of	contributing to death but not res	sulting in the underlyi	ng cause given i	in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?	
rds	w requires been sign should be	ed by						10	Yes 2	□No 3□P	robably 4 Unknown	1
eco	law re	Completed						24a. Wa auto	ODSV	prior to	utopsy findings available completion of cause of	3
<u>=</u>	: The law cate hes ; page 2 :	Con						1 X Yes	formed? 2 ☐ No	death?	s 2 No	
Z.	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? >> X S Yes 2 □ No	Hospital: 1 ☐ Inpatient 25	ER/Outpatient 3□	Other	6. Place of Dea			6 ☐Other (Spe	erifu)	
οt	g Phy ter this neral d	in: Tó	27. Manner of Death	28a. Date of Injury FIGMonth, Day Year)		28c. Injury at Work?		28d. Describe			ink	
sior	or Attending after death. Director: After in by the fune	catic	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 【A Could not be	Jan. 6, 2006	12:58 A ^M	1 🗆 Yes	2 No	001	(0)			_
Division of Vital Records, P.O.	oepital or Attendi hours after death. unerel Director: A ly filled in by the f	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, fa ify)	ctory, office		City or To	own, State	•) 1834 E.	iural Route Number, 28th St.	
	I 4 F 0	Medical C		nysician: To the best of my knominar: On the basis of examinar and manner stated.				, and due to the	e cause(s) and manner a		
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and mannor stated.		29c. License ne	umber		29d. Da	ite signed (Mon	th, Day, Year)	_
			I Jamel Frut	hall mi		OCME			Janu	ary, 6,	2006	
7	P		30. Name and address of person who	completed cause of death (Iter		111 Por	n Strac	+ Dol+	imor	o Morri	dand 21201	
(V	- C10	10	31. Date filed (Month, Day, Year)	(†//2(M)) 32. #gistrar's Sign		111 Pen	n srree	r Dall	LHOL	e, mary	land 21201	_
	Sta Registr			2006	B Board	2						

DHMH 17 Rev 1/2001

ORIGINAL

				Unpend Amend item#	Type or Pri	nt in Blac pen E, go	k Inde	lible Ink.	Ensure Al	I Copies	Are Legi	ble.	
				1 - For State Registrar	State of Ma	aryland / I	•	ment of He iicate of D	ealth and M Death	,	giene Reganol ()	6	00456
				1. Decedent's Name (First, Middle, La	ıst)					2. Date of De	ath	<u>U</u>	3. Time of Death
4		Physici /Medi		Rodne	ey Gerald	Davis	5			January	y 10, 20	906	2:45 A M
•	7	Examir		4a. Facility Name (If not institution, given			46		Location of Death		4c. County		
	1			Harford Memorial 5. Social Security Number 6.5		e (In yrs. last bi	intholou) If		De Grace			rfor	
		Funeral Director		215-90-3553	Sex. 7. Ag 1 AM 2□F	32		onths Days	Hours Min.	8. Date of Bir (Month, Da OCT 24	, 1973	9. Birth Cou M:	nplace (State or Foreign untry) aryland
		yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Location	on					10d. Inside City Limits
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventrer must be notified at ance.	Director	Maryland Harfo	rd			Abero	leen				1 ☐ Yes 2 X No
		with the or 2	Die	10e. Street and Number			1	Of. Zip Code	_		10g. Citizen of 1	What Cou	intry?
		ns 23	Funeral	6 Aberdeen Avenu	e 12. Was Decedent	Ever in U.S.	13. Was	2100		acify Yes or No	USA 14 Bac	a - Amar	ican Indian,
	9	after or iter	Fun	1X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐X				spanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	Bla	ck, White	, etc.
	003	ours aral', c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 1 1	Yes 2XNo	Specify:		Specify	c W	hite
5	Maryland 21215-0036	in 72 h "natu edice	Completed	15. Decedent's E (Specify only highest gr	ade completed)		. Decedent' (Give kind	's Usual Occupation of work done du	tion uring most of worki	ng	16b. Kind of B	ısiness/lr	ndustry
24	212	d with giene. rr than	шо	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Disab				N	/ A	
0	pu	al Hyg	Bec	17. Father's Name (First, Middle, Last)		DIDGE		18. Mother's Name	(First, Middle,		1 + +	
	Val	ould b Ment arkac	To T	Felix Davis							cia Eppe		
	Mar	12 sh n and n sm rsm raum	4	19a. Informant's Name/Relationship	** '				nd Number or Rura				p Code)
0		1 and Healtl am 27		Felix Davis/Fath 20a. Method of Disposition	er	20b. Place o		rdeen A		erdeen	MD 210		Tourn Chata
0	nor	ages int of t: If it y or o		1 ☐ Burial 2XQCremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specie		cemete	rry, cremato	ry or other place,)				
1/10/06	Baltimore,	nit. Prartme		21. Signature of Funeral Service Lice	• • • • • • • • • • • • • • • • • • • •	Metro		atory, 1 Ime and Address	nc. 1/12,		Balti		
10	ñ	Dep June any	1	Edward A. Gre	gorchik				Cre cick koad	emation Balti	More, M	y of	MD, Inc.
>			11000	23a. Part1. Enter the discusse, or comshock, or heart failure. List only		the death. Do						0 21.	Approximate Interval Between
4		Physician		Immediate Cause (Final disease or condition	D.	tin c	1,000	<u>~ 1</u>	Brain tu				Onset and Death
2		/Medical Examiner		resulting in death)		a consequence	of):	10 1	/				
1.		LAGITITICI		Sequentially list conditions,	b. Dun 2017	a consequence	THY	NOY		1		4.	
13		uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C - C -	a consequence	9 .		0//				
K	ó	be executed ician and burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (or as	a consequence	oi):	~	/ 				
13	3760,		<u>a</u>		0. SCT	Zure	1		RIF CATION APPRO	MEDICAL	LEXAMINER		
7×	(68 ⁷	artifica ing ph e as th	Med	IF FEMALE:				- 6	ALON MODEO	NED BY WILL			
>	Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal death			RINA		23d. Dat	e of deliventh	ery Day Year
P	P.O.	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Medic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death	5 U Oth	ner (specify)					Duy Tour
7		s that ned b e deta	by Pr	Part II. Other significant conditions of	contributing to death bu	ut not resulting in	n the underl	lying cause given	in Part I.	23e. Did to	bacco use conti	ibute to t	he cause of death?
Sodi	ecords,	v require been sig should b	ed b	Cocaine use						1 🗆 Y	′es 2□No	3 Prot	bably 4 Dunknown
α	ecc	law requas been 2 should	Completed							24a. Was autop	an 24b. V	Vere auto	opsy findings available ompletion of cause of
<u></u>	α	'sician: The law s certificate has E lirector, page 2 s	Con							perfor	med2 o	leath?	
VI	Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Othor	26. Place of Death	(Check only or	ne)		
>	o	ding Phys h. After this funeral dii	- To	1 XYes 2210 27. Manner of Death	1 / Inpatiei		itpatient 3 Time of	DOA Other	4 Nursing Hom		ence 6 Othe		١)
0	ion	Attending r death. ector: After	atior	1 ■Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	Year) I	njury	Work?	es 2 □No	od. Doddiba ii	ow injury coodin	30	
1	Division	r Attendi er death. rector: A by the fu	Certification;	3 Suicide 6 Could not b	e 28e. Place of Inju- building, etc	ıry - At home, fa	ırm, street, f	actory, office	2	8f. Location (S City or Tow	treet and Number	er or Rura	al Route Number,
	Ō	oital oi urs aft iral Di											
		To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best on niner: On the basis of and manner sta	examination an	a, death occ id/or investig	urred at the time gation, in my opir	, date and place, a nion, death occurre	nd due to the o d at the time, o	ause(s) and ma date and place, a	nner as s ind due to	tated. the cause(s)
		To th withir To th comp	Me	29b. Signature and little of certifier				29c. License r		2	29d. Date signed	(Month,	Day, Year)
		0						200	62908		01/10/0	6	
		(3)		30. Name and a sess of person who	completed cause of de	eath (Item 23a) ((Type, Print)	11	۸	(= 1	13	0 0	
		Sta	te	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	700	uph U	non 1	Ve		107	rau, MI)
		Registr		JAN 1 2 20	06 Marie	, A.	Goods					14 (0

				State of M		artment of Health and N			00157
		70		For State Office	Ce	rtificate of Death	1	Reg. No.	00437
		Physici		Decedent's Name (First, Middle, Last) To accoming the Polyton Po			2. Date of De Month	Day Year	
		/Medi Examir		Joseph Peter Detorie, Jr 4a. Facility Name (If not institution, give street and numbe		4b. City, Town, or Location of Death	Janua	4c. County of De	6 11 3
				Franklin Square Ho	spital	Rosedale		DI	more.
	· •	Funeral		5. Social Security Number 6. Sex 7 220–20–1265 €. Sex 2□ F	Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da July 1.		rthplace (State or Foreign country)
	er.	Director		Usual Residence of Decedent	76 115		July 1.	3,1929 Mar	ryland
		show	_	10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
		the M.	Directo	Maryland Baltimore 10e. Street and Number	Essex	10f. Zip Code		10-07	1 Yes 2 XNo
		h with		1527 Nicolay Way		21 221		10g. Citizen of What C	ountry?
		r deat	Funeral	11. Marital Status 12. Was Deceder Armed Force	nt Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto			
4	36	rs afte	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 [If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date:	No TATATT	1 ☐ Yes 2 ☒ No Specify:	, , ,	Specify	
oseph	21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. id other than "natural", or Itema 23a or 28e-f show event, the Middral Exeminar must be notified at	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b. Kind of Business	White s/Industry
SO	121	vithin ne.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	or 5+)	kind of work done during most of work DO NOT use retired)		D-1-'1 D-'-	al Glassia
2	d 2	filed v Hygie other t		17. Father's Name (First, Middle, Last)	Manage			Retail Pai	nt Store
و	Maryland	2 should be filed and Mental Hygi Is marked other aumatic event,	To Be	Joseph Peter Detorie				nia Dinun	zio
	Mary			19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rura			
7		tan teall sm 2		Margaret Kathryn Detorie (1 20a. Method of Disposition		Nicolay Way, Balt sition (Name of matory or other place)	Date	20c. Location - City o	
	o L	m O		1 ★ urial 2 □ Cremation 3 □ Removal from State 4 □ Donation - 5 □ Other (Specify)	LO	matory or other place) LL Mem. Gard.Jan.1	3.2006	·	
1	Baltimore,	permit. Page Department of Important: If eny injury or once.		21 Siponture of the Coloresee		2. Name and Address of Facility Bruzdzinsk			
		20559				1407 Old Eastern A	venue,	Essex, Mar	yland 21221
				23a. Part1. Enter the disease, or complications that caus shock or heart failure. List only one cause on each Immediate Cause (Final	ed the death. Do not ent line.	er the mode of dying, such as cardiac	or respiratory ai	rrest,	Approximate Interval Between Onset and Death
	1	Physician /Medical		disease or condition resulting in death)	as a consequence of):	^e			imonth
	П	Examiner		NA. IO	cardial	Infarction	\		lyear
		pe list	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of):	0 111:			
P	,	te be executed ysician and e burial-transit	Examiner	that initiated events c. Due to (or a	ectious (COLLES			Imonth
	3760,	20	cal	d					
	99 x	eath certificat attending phy I for use as th	/Med	IF FEMALE: 23c. If yes, outcom	o of programs.				
	Во	sattene affor us	by Physician/Med	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
	Ö.	res that the de signed by the a be detached f	hysi	9 Unknown 9 Unknown					
	Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. Campletely filled in by the funeral director, page 2 should be detached for use as the	by F	Part II. Other significant conditions contributing to death	but not resulting in the un	nderlying cause given in Part I.		obacco use contribute to	
	Sorc	w requir been si should I	Completed						robably 4 Tunknown
	Rec	The lay cate has page 2	dwo				24a. Was autop perfo	rmed? prior to death?	utopsy findings available completion of cause of
	ita	ian: T	Be C	25. Was case referred to medical		26. Place of Death			2 □ No
	of V	ding Physician: After this certific funeral director.	2	examiner? 1 Yes 2 No Hospital: 1 Inpa		t 3 DOA Other: 4 Nursing Ho		lence 6 □Other (Spe	cify)
	Ouo	ding F h. After funera	tlon:	27. Manner of Death 1. Natural 5 Pending (Month, Decident investigation)	jury 28b. Time of lay Year) Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe h	now injury occurred	
	Visi	Aften ar deat ector: by the	Certification:	3 Suicide 6 Could not be	njury - At home, farm, stre		28f. Location (S	Street and Number or R	ural Route Number,
	۵	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: cumpletely filled in by the		- Callang,	etc. (Specify)		City or Tow		
		Hosp 24 hou Fune stely fill	Medical	29a. Certifier (Chack only one) 1 Certifying Physician: To the best and manner:	of examination and/or inv	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the ded at the time, d	cause(s) and manner as date and place, and due	s stated. a to the cause(s)
		To the	Me	29b. Signature and title of certifier	nateu.	29c. License number		29d. Date signed (Mont	h, Day, Year)
				1 / L, MO		D006313	٠	January 10	2006
_		141		30. Name and address of person who completed cause of	death (Item 23a) (Type, I	Print)			
	100	Sta	te	31. Date filed (Mohth, Day, Year) 32. Abgis	trar's Signature	Square Drive	Dut	More) MI	3 2143 /
		Registr		IAN 1 9 2006 A	M. Ra	and I			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Helen Elizabeth DeFrancesco January 8, 2006 3:00 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 45 Delaware Avenue Apt 12 Hurlock Dorchester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Director 87 Yrs. 219-40-9647 Germany 1919 Jan. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f shov MD Dorchester Director Hurlock 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Delaware Avenue Apt 12 21643 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. other traumatic event, the Madical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 🎇 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Maid Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 Bruno Wensein Freida Henze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tom Dietz 14 Benjamin Way, Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 X Cremation 3 □ Removal from State ŏ any injury once. ' 4 ☐ Ponation _5 ☐ Other (Specify) Bayview Crematory, Inc. 1-11-2006 Baltimore, MD Signature of Funeral Service Li 22. Name and Address of Facility Amnrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final havir Obstruction **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 Yes 2 🗆 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 24 hours a Funeral I 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the best of my knownedge, death occurred at the limb, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) the the 29b. Signature and title of certifier 2 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 302 Cd/Ms 140 22. Registrar's Signature 31. Date filed (Me State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00459 State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 0 Rosa Lee Dawson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Peninsula NICOMICO medical Cente alisbu gional Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number . Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 ☐ F Yrs. 219-22-2167 August 13,1929 Maryland Director 76 Usual Residence of Decedent the Maryland 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State 28e-f ehow other treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Worchester Ocean City 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number or items 23a or 21842 United States 511 Sandy Hill Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "natural; or iten eny injury or other freumatic event, the Medical Externment once. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify:White ģ 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) business office clerk telephone company 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bessie E. Eisel Holland H. Burnett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 32039 Bonhill Drive, Salisbury, Maryland 21804 Douglas C. Dawson - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Loudon Park Cemetery 1/10/2006 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit ullmom Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnapt 3 Ectopic pregnancy Day Month Year in the past 12 mont 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ N6 sate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of dath? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be To 1 Inpatient 1 Yes 2 No 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ή MILFORD ST, SULTESB, SAUSBURY, mp 2180 4 106 PIOSH NEHAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State	of Marylai		ertment of tificate o		d Mental Hy	giene Reg. No.	06	00460
2 3	Physici	, an	1. Decedent's Name (First, Middle, I	.ast)					2. Date of De Month	aath Day	Year	3. Time of Death
	/Medic	al	Armina E. Dudec						Janua		,	4:00 PM
	Examin	ier	4a. Facility Name (If not institution, g					or Location of D timore	eath	4c. Co	unty of Death	
<u> </u>	Euparal	~	Union Memorial 5. Social Security Number 6	Sex	-	. last birthday)	If Under 1 Yea			th	9. Birth	place (State or Foreign
	Funeral Director		164-38-8386	1 ☐ M 2 🛱 F	87	Yrs.	Months Day	s Hours M	Min. (Month, Di	ay, Year)	Con	sylvania
8.	pu ,		Usual Residence of Decedent						трі ії			
	ehow	7	10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	28a-1	Director	MD 10e. Street and Number			Baltimo				10- 02		1 Yes 2 No
	with a or			- A==0===			10f. Zip Code			-	of What Cou	intry?
	death with the Maryland ms 23a or 28a-f ehow crivet be notified at	Funeral	2211 West Rogers	12. Was De	cedent Ever in t	U.S. 13. V	Vas Decedent o	21209 I Hispanic Origin	? (Specify Yes or N		SA Race - Amer	ican Indian.
٥	or iter	F.	1 Never Married 2 Married	Armed I	Forces?				? (Specify Yes or No Puerto Rican, etc.)		Black, White	
3-003p	hours after turel', or ite	l by	3 X Widowed 4 ☐ Divorced	If Yes, C Year or	aive Dates:		I□Yes 2¶ N	o Specify:		Sp	ecify: wh:	ite
	d within 72 hours after death with the Marylan liene. I then "naturel", or items 23a or 28a-1 ehow the Madical Examiner must be notified at	Completed	15. Decedent's (Specify only highest of	Education grade completed	d)	16a, Deced	lent's Usual Occ kind of work dor	upation ne during most of	f working	16b. Kind	of Business/l	ndustry
7	within 72 ene. then nai	mp	Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT use reti				1 1.1	
2 0	be filed a ntal Hygie od other i	e Co	12 17. Father's Name (First, Middle, La	st)	3	re	gistere		Name (First, Middle	. Maiden Su	healtl	1
yland	0 = 0 >	To Be	Earl Clifford S	•					na Beatrix			
	should ind Men ind marke	-	19a. Informant's Name/Relationship			19b. Mailin	g Address (Stre	1	or Rural Route Numb			p Code)
Z	d 2 th a 17 is		Virginia Mille	r/daugh	ter	2211	South R	oad Balt	imore, MI	2120)9	
Baitimore,	pernit. Pages 1 an Department of Heal Important: If item 2 any injury or other 2005s.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☼ Donation 5 ☐ Other (Spe			Place of Dispo cemetery, cren	sition (Name of natory or other p	lace)	Date	20c. Local	ion - City or T	own, State
Pait	permit. Departn Imports any inju		21. Signatur of Funeral Service Lice Ronald S	ensee Wade	Vireeto				ard 655 W	. Balt	imore	Street
- 6	· =-•		23a. Part1. Enter the disease, or co shock, or heart lailure. List on	mplicatione that	caused the dea	ath. Do not ent	er the mode of d	ying, such as car	rdiac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_	un sem	· 6						Onset and Death
	/Medical Examiner		resulting in death)		o (or as a conse							10 20075
	Examiner	_	Sequentially list conditions,	b. <u>I</u>	nfection		itis					1 month
	bed Isit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a conse	quence oi):						
	and and al-trar	Examiner	that initiated events resulting in death) Last	c	o (or as a conse	quence of):						
9/8	icate be executed physician and s the burial-transit	edicai I		d								
Q Q												
X Q Q	death certific e attending p id for use as f	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		outcome of pregr		Ectopic pregnar	ncy		230	. Date of deliv	•
o.	0 0	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pre 9□ Unk	gnant at time of mown	death 5□	Other (specify)			100	Month	Day Year
7	that the ed by detac	Ph.	Part II. Other significant conditions	s contributing to	death but not re	sulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
Hecords,	law requires that the as been signed by th 2 should be detache	d by				, and the second	, ,		1 🗆	Yes 2 😿	No 3 Pro	bably 4 Dunknown
င္ပ	s been si should t	Completed							24a. Was	an 2	4b. Were aut	opsy lindings available
Ÿ	0 - 0	mo							auto perf	psy omed?	prior to co death?	empletion of cause of
Vital	sician: Th certificate rector, pag	BeC	25. Was case referred to medical	1				26. Place of	1 ☐ Yes Death Check only	2 No No	1 🗆 Yes	2 NO
<u> </u>	Physic this ce al direc	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2	☐ ER/Outpatier	t 3 DOA	Whon	ng Home 5 🗌 Res		Other (Spec	fy)
Ē	ding Pl h. After ti funera		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Dat (Mo	e of Injury onth, Day Year)	28b. Time of Injury	V		28d. Describe	how injury o	ccurred	~
<u> </u>	Mtendi death. ctor: A y the fu	cat	2 Accident investigat 3 Suicide 6 Could no	the -	1122			☐ Yes 2 ☐ No				
Division of	al or Al after of i Direct d in by	ertification:	4 Homicide determine	ad 288. Pla	ce ol Injury - At Iding, etc. (Spec	nome, larm, str cify)	eet, lactory, offic	ee e	City or To	Street and N wn, State)	lumber or Rui	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificicompletely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	aminer: On the	he best of my kr basis of examinance stated.	nowledge, death nation and/or in	n occurred at the vestigation, in m	time, date and p y opinion, death o	place, and due to the occurred at the time	cause(s) an	d manner as ace, and due	stated. to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	0.0			29c. Lice	nse number		29d. Date s	igned (Month	Day, Year)
)			Ellest	lue	20		Hou	61180		C	1/09	106
			30. Name and address of person wi	o completed ca	use of death (Ite	em 23a) (Type,	Print)				- /	/
	% C.W.O.			lhiveni	Hadistrar's Sin	nature -	179	/ himire,	mn 2	112/5		
	Sta Registi		JAN 1 2	2006	Section of	the state	Section 1		mo z			

			For State Registrer	State of Ma		epartment Certificate				ene 006	00461
			1. Decedent's Name (First, Middle, La	st)				2	Date of Death Month	Day Your	3. Time of Death
	Physici /Medic		Robert Lawrence	Field				Ja	anuary	4, 2006	6:30 P M
	Examin		4a. Facility Name (If not institution, giv	street and number)		4b. City, T	own, or Location	n of Death		4c. County of Deat	th
			Berlin Nursing				rlin			Worceste	
	Funeral		5. Social Security Number 6. S	ex 7. Age ☑M 2□F	e (In yrs. last birth	Months	Days Hours		Date of Birth (Month, Day, 1	(ear) 9. Birt	thplace (State or Foreign ountry)
	Director		190-20-6350 Usual Residence of Decedent	X	78	S.		J.	an 11,	1927 Penr	nsylvania
	and and		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	Mary	to	MD Worcest	er	Ве	rlin					1 ☐ Yes 2√ No
	28a	Director	10e. Street and Number			10f. Zip (Code		10	g. Citizen of What Co	ountry?
	within 72 hours after death with the Maryland ene. Than "natural", or tiems 23e or 28e-f show he Madrell Extenition must be notified at	O in	53 Fairway Lane				218	311		USA	
	death	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Decede			y Yes or No-	14. Race - Ame	
9	after or the	T.	1 ☐ Never Married 2 X Married	1 XYes 2 1	No	1 ☐ Yes 2			an, etc.)	Black, Whit	
ဋ္ဌ	ours iral',	d by	3 Widowed 4 Divorced	Year or Dates:	45-46	10103 2	A NO Specif	, y .		Specify: W	1116
21215-0036	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(1	ecedent's Usual Give kind of work	k done during me	ost of working	11	6b. Kind of Business/	Industry unk
12	mithin than	mp	Elementary/Secondary (0-12)	College (1-4or 5	j+)	ife. DO NOT use					
N	filed withir Hygiene. other than ent, It's M		12 17. Father's Name (First, Middle, Last,	5+		asses		ther's Name (f	irst Middle M	aiden Sumame)	
ano	ntal I	Be									
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	10	Lawrence Norton 19a. Informant's Name/Relationship (19b M	Mailing Address			elvina	City or Town, State, 2	Zin Code)
₹	id 2 s Ith ar 27 is trau		Isabel Field/spo			} Fairwa				1811	-,
ā,	s 1 and 2 should be filed within 72 hours after death with the Marylan fer Health and Mental Hygiene. The ferm 23 or 28a-f show item 27 is marked other than "natural", or ttems 23a or 28a-f show item 27 is marked other than "natural", or ttems 23a or 28a-f show item 27 is marked other than "natural", or ttems and the notified at		20a. Method of Disposition		20b. Place of E	isposition (Nam	e of	Dat		Oc. Location - City or	Town, State
no	Pages nent of int: If it		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specif		cemetery,	crematory or oth	ner place)				
Baltimore,			21. Signature of juner Service Licer			22. Name and	Address of Fac	ulity	·		
Ba	permit. Departr Imports any inje		Manald S	Wade, Dire	ector				055 W.	Baltimore	Street
			231. Part1. Enter the disease, or com	plications that caused	the death. Do no	t enter the mode	re, MD of dying, such a	as cardiac or r	espiratory arres	st,	Approximate Interval Between
	Thysician :		shock, or heart failure. List only Immediate Cause (Final	AH	/- /	1.	dio varce	1 /)>		Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or as	a consequence of		MINO V DISC	ular L	1>000		1 Eurs
	Examiner		Conventially list assertitions	b		*					
	D #	ner	Sequentially list conditions, any lacons of introductions cause. Enter Underlying Cause (Disease or injury		a consequence of						
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burtal-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
8760,	cate be execu ohysician and the burial-tra	0	1650king in death) Last	Due to (or as	a consequence of	:					
87	cate t	dica		d				-		-	
9 x	eath certiffi attending p I for use as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					201 0 1 11	
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pre 5 □ Other (spe				23d. Date of del Month	Day Year
o.	that the death ed by the atter detached for	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	timo di addin	0 <u>—</u> 0 (1.0) (9)0					
ص ّ	res that the igned by be detact	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in t	he underlying ca	use given in Par	rt I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	uires n sign	d by							1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Unknown
00	w requir been s should	iete							24a. Was an	24b. Were au	utopsy findings available
Re	he lav e has	Completed							autopsy perform	prior to death?	completion of cause of
Vital		a l	25. Was case referred to medical		- -		26 Pla	ice of Death //	1 Yes 2 Check only one	No 1 □ Yes	2□ No
<u>=</u>	Physician: The la this certificate har ral director, page 2	O B	examiner? 1 🗆 Yes 2 🗙 No	Hospital:	ent 2 ER/Outp	atient 3 DO	Other /			ce 6 Other (Spe	cify)
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<u>o</u>	Attending Ph r death. ector: After th by the funeral	atio	Natural 5 Pending 2 Accident investigation		y rear/ III]	M	1 ☐ Yes 2	□No			
Division	er de recto by th	tific	3 Suicide 6 Could not b	e 28e. Place of Inj	ury - At home, farn c. (Specify)	n, street, factory,	office	281	Location (Stre	eet and Number or Ru State)	ural Route Number,
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	To the Hospital or Attend within 24 hours after dealt To the Funeral Director: completely filled in by the		(Check only 2 Medical Exa	ysician: To the best niner: On the basis of	f examination and	death occurred a	it the time, date	and place, and	due to the cau	use(s) and manner as	s stated.
	the F the F the F	Medical	one)	and manner sta	ated.						
	To To Con	2	29b. Signature and title of certifier	11	,	290	License numbe	10	29	d. Date signed (Mont	n, Day, Year)
			111/VO Mr	win	- 6	4	12016	67		1/200	6
			30. Name and address of person who	completed cause of d	leath (Item 23a) (T	ype, Print)	Conte	0/4	Fr.	et Tel	10- 190114
			31. Date filed (Month, Day, Year)	3 Registr	ar's Signature	10000	2000	ITTWE	y I UW	M 48 lice	10(11997
	St: Regist		IAN 1 2 20	06 Maria	, B. A.	DENEL!		,			

DHMH 17 Rev 1/2001

Field, Robert L.

Amend Item#18 per FH G8521278/06/lend / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01 2006 Year **Physician** 06 George Harry Fralley 06:35am /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brookgrove Nursing Home Sandy Spring Montgomery If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 82 vrs 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours MOXM 2□ F 145-12-8362 Director 02/26/1923 New Jersey Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or Items 23a or 28e-f ahow ampiriquey or other traumatic event, the Medical Examinet must be ricitlified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD 1 ☐ Yes 2 🔯 No Montgomery Silver Spring Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15101 Interlachen Dr. #826 20906 TISA 12. Was Decedent Ever in U.S. Armed Forces? 1942-47 NEXYes 2 No 1950-54 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian, Black, White, etc. 11 Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 200 No Specify: Completed by 3 □ Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Government Elementary/Secondary (0-12) College (1-4or 5+) 4 Civil Servant Government 18. Mother's Name (First, Middle, Maiden Sumame)

Honeker

Anna Elizabeth 17. Father's Name (First, Middle, Last) æ Anna Elizabeth George Luce Fralley ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Fralley/daughter 15101 Interlachen Dr. #826 Silver Spring MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 01/11/06 Beltsville MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Rapp Funeral & Cremation Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mo135 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Congestive Heart Failure 3 weeks Examiner Due to (or as a consequence of): Physician/Medical Examiner Arteriosclerotic Heart Disease 15 years or Attending Phyalcian: The law requires that the death certificate be executed for use as the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? page 2 should be deteched 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Obstructive Pulmonary Disease Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Chronic Renal Insufficiency 1 ☐ Yes 2 🖾 No 1 □ Ves 2 □ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🔯 Nursing Home 1 Yes 2 No Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 🖳 Natural 5 Pending efter death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 🗌 Homicide within 24 hours e Hoapital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 01/06/2006 D24543 In alm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. Rossi 3305 N. Leisure World Blvd. Silver Spring MD 20910 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 2 83425 Registrar

		1	For State Registrar	State of Ma		partment of F ertificate of			gienę () () Reg. No.	6 00463
5 2-8 %	Physicia		1. Decedent's Name (First, Midd		T 1	1	211011	2. Date of De Month	Day	3. Time of Death
4	/Medic	al -		LVET	F- L-	NDERE		JANUARY	4c. County of	6:32PM
	Examin	er	4a. Fecility Name (If not institution Bon Secours He			Baltir	r Location of Death		n/	
	Funeral	311	5. Social Security Number	6. Sex 7. Ag	e (In yrs. iast birthda			8. Date of Bir Month, Da JAN 16		9. Birthplace (State or Foreign
17	Director		214-40-2366	1X M 2□F	63 Yrs.	Working Days	Tiodis Iviii.	JAN 16	1942	SC
	land DW	-	Usual Residence of Decedent 10a. State 10b. Count	/	10c. City, Town or	Location				10d. Inside City Limits
	Mary	to	MD n/a		Baltimor	:e				1 X Yes 2 □ No
	or 284	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
	23a	la l	1704 Poplar			212		7 7	USA	
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Iteme 23a or 28a-f ehow event. The Mcdical Exerting I and the notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 💆 Divorce	If Yes Give		3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No	an, Mexican, Puerto Specify:	ecry Yes or No Rican, etc.)		- American Indian, White, etc. black
2-0	72 ho	Completed		nt's Education	(Gi	cedent's Usual Occup ive kind of work done	during most of work	ang	16b. Kind of Bus	iness/Industry
121	vithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or	5+)	e. DO NOT use retire	d)	,	Constru	action
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lan	lid be lental ked c	To Be	Doffies Fun	derburk			Gessie	Black	mon	
Maryland	and Notes		19a. Informant's Name/Relation			ailing Address (Street	_			tate, Zip Code)
∑,	and i		Maggie Jone	s - sister		+ W. Ivy Lasposition (Name of	, ,	ewood,		City or Town, State
Baltimore,	permit. Pages I and 2 should be Department of Health and Mental Important: If Item 27 is marked eny injury or other treumatic ev <u>gnce</u> .		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other		cemetery, c	crematory or other pla ake Cremat	cory 1/10)/2006_	Beltsvi	
Balt	Departiment Important		21. Signature of Funeral Service	e Licensee	M00986	CAFA, Ste	phen D. L	ohrmann	, PA	ND 04006
· E	****		23a. Part1. Enter the disease,	or complications that cause		8717 Greet enter the mode of dyi				Approximate
-	Physician		Immediate Cause (Final	st only one cause on each l	-	ENZEPH,	21/2PAT	HN		Interval Between Onset and Death
See also	/Medical		disease or condition resulting in death)	Don't to form				/		
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<u> </u>	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):	L 120172	FL FL 1) 1-1	2,2	7 179 2	21,01,000
68760,	icate be executed physician and s the burial-transit	dicai		d						
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O. Box	or Attanding Physician: The law requires that the death certifi titer death. Director: Atter this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	У		23d. Date Mon	of delivery th Day Year
Δ.	es that gned b	by Pł	Part II. Other significant condi			e underlying cause gr	ven in Part I.	23e. Did	tobacco use contri	bute to the cause of death?
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ecc	law r nas be	Completed	SE12	LURE DIS	0户17万尺	.em		24a. Was	s an 24b. W	ere autopsy findings available for to completion of cause of
E H	: The law icate has ; page 2 :			3 STANCE	4345E			1 ☐ Yes	2 No 1	eath? □Yes 2□No
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ō	iding Phys th. After this funeral di	n: To	27. Manner of Death	28a. Date of In	ury 28b. Tim	e of 28c. Inju	iry at		how injury occurre	
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Division	al or Attendi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Cou	minod 288. Place of It	njury - At home, farm atc. <i>(Specify)</i>	street, factory, office			(Street and Number own, State)	r or Rural Route Number,
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	To t with: To t com	Σ	29b. Signature and title of certification. 30. Name and address of personal states of pe	fier SU	Pars-	29c. Licen	33 <i>00</i>		JANUA	(Month, Day, Year) -7 06 2006
	3		30. Name and address of person	on who completed cause of	death (Item 23a) (Ty	rpe, Print) 1301	SELOW	ES HO	351TA2	
			31 Date filed (Month Day Vo	D. MAIE.	trar's Signature	OW: 13A	-27/MUR	E 3T'	BAZTO,	r1D. 21223
	St Regist	ate rar	17N 1 9	2006	, St. A	2162)				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan **Physician** 6 ay Marshall Griffin 2006 5:10A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-11-48 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours XIM 2□ F 214-48-0002 57 MD Director Usual Residence of Decedent 1 and 2 should be filled within 72 hours after deeth with the Maryland Health and Mental Hygiene. em 27 ie marked other then "naturel", or Iteme 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County traumatic event, the Mudical Examiner must be notified at MD Baltimore 1 ☐ Yes 2 🔀 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3212 The Alameda 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 Ϊ No Specify: Black Specify: 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Diesel Mechanic City Balto. Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joe McLeod Marion Griffin 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Scott (Ex-Wife) if item 27 i 3212 The Alameda Balto. Md 21218 other ! Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place Garrison Forest 20a. Method of Disposition Date 20c. Location - City or Town, State Pages XX Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Depertment of important: if eny injury or once. 1-11-06 Owings Mills,MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wesley Chavis, Jr. 21. Signature of Funeral Service Licenses 2007 Eastern Avenue Balto. MD 21231 23a. Part1. Enter the disease, or complications that ca shock, or heart failure. Ust only one cause on e Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physiclan/Medical Examiner The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physic IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy perform Vital 1 ☐ Yes 2X No or Attending Physician: After this certific funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Medical Certification; To 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred **bivision** 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: within 24 hours after dea To the Funerel Director completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

6,

FANUARY

MARSHALL GRIFFIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Megistrar Amend Item #1 Per PHY C851 Certificate of Death
Decedent's Name (First, Middle, Last) Reg. No. 2. Date of Death **Physician** Month Vear 1603 Esther **Holt** 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Honewood. Klersme Facility But mere
If Under 1 Year | If Under 24 Hrs. | 7 Age (In yrs. last birthday) 82 Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🔀 F 219.05.7799 MD Director Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at NIA MD Baltimore 1 SeYes 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6000 Bellona Avenue 21212 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☐ No Black Specify: 3 ₩Vidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n College (1-40(5+) Elementary/Secondary (0-12) Domestic 12th grade tomemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental Bruant Charles Germade 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a important: If item 27 is any injury or other traigness. Place of Disposition (Name of Baltimore, Method of Disposition Burial 2 Cremation 3 Removal from State Zion (enetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 6 MD 2124 23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. lying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronary arteru /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medicai the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 own Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate 1 Yes 2 No Division of Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Medical Certification: To 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral director. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and little of gertifier 29c. License number 29d. Date signed (Month, Day, Year) D0059423 30. N. e and address of per will who completed calle of death (Item 23a) (Type, Print) Good Saniar Anthos Perforce 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2006

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00466 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day Physician 8 1 2006 12:50p /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (Whot institution, give street end number) 4c. County of Death Examiner Salfimore omure If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number (In yrs. fast birthdey) **Funeral** Birthplace (Stete or Foreign Country) Days Months Hours 1 □ M 2 💢 F Yrs. Director 214-40-2687 4-26-36 Ala. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director NA Md. Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 2432 Brentwood Avenue 21218 USA 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2X No Specify: Specify: Š 3 ☐ Widowed 4 ☐ Divorced Black Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) llth grade Homemaker Own Home Pages 1 and 2 should be filed nant of Health and Mentel Hyginit: If Item 27 le marked other **Baltimore, Maryland** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Alphonso Ware Lula 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clinton Heard Husband 21218 2432 Brentwood Avenue, Baltimore, Md. other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ò Depentment important: If Garden of Faith 1-13-06 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ada March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. wan Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed betes 1 ☐ Yes 2 10 No 1 ☐ Yes 2 ☐ No completely fillad in by the funeral director, Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Menner of Death Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 🗆 Yes 2 🗆 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, Division of Vital Records, P.O. or Attending Physician: death. aftar death Director: Hospital

24 hours within 2

State Registrar

edicai

4 ☐ Homicide

29b. Signature and title of certifier

31. Dete filed (Month, Day, Year)

JAN 1

Loch

2 2006

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

29a, Certifier (Check only one) 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29c. License number

29d. Date signed (Month, Day, Year)

Winumy 10, 2006

			For State Registrar	State of M	aryland /		artment tificate			ind M		giene	106	00467
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last, James M. Hailey								2. Date of Dea Month Jan. 8,	Day 2006		3. Time of Death 10:30 A ^M
	Examin Funeral Director		4a. Facility Name (If not institution, give 10735 Hewitt Farm 5. Social Security Number 2/2 26 1712	s Rd.	je (In yrs. last 81	<i>birthday)</i> Yrs.	_	gs M	Location o Iils If Under 2 Hours	24 Hrs.	8. Date of Birtl (Month, Day)ct. 21	h I	Saltimo Baltimo 9. Birth 24 Nort	
	ס	tor	242-26-1712		10c. City, To	own or Lo				[, 232		10d. Inside City Limits 1 🗆 Yes 🛂 No
-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show apply injury or other traumatic avant, the Medical Examinar must be notified at once.	ed by Funeral Director	10e. Street and Number 10735 Hewitt Farm 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1↓□Yes 2□ If Yes, Give Year or Dates:	^{No} 1344			1117 ent of Hir ify Cubar	spanic Orig n, Mexican Specify:		cify Yes or No- Rican, etc.)	. 14		nican Indian, a, etc. Black
	be filed within 72 al Hygiene. I othar than "natavant, the Wede.	Be Completed	(Specify only highest grad Elementary/Secondary (0-12) 7 17. Father's Name (First, Middle, Last)			(Give	kind of wor DO NOT us	k doné d e retired)	uring most		(First, Middle,	Hos	of Business/ Spital Gurname)	industry
	and 2 should balth and Ment 27 is marked or traumatic a	To	Sylvester Hailey 19a. Informant's Name/Relationship (T) Yolonda Hammond —		1	.0735	Hewi	(Street a	arms		Route Numbe			
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8760, <	cate be executed Whysician and physician and it is the buriat-transit	dical Examiner	23a. Park. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Deep Due to (or as co.	d the death. If the death of th	Ce of):	nbolu.	of dying	g, such as		Altimoi		ID 2127	Approximate Interval Between Onset and Death MINULES
.O. Box 6	that the death certific ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3[Ectopic pre					23	3d. Date of deli Month	ivery Day Year
rds, P.	w requires that the been signed by th should be detache	by	Part II. Other significant conditions co	ntributing to death	out not resultin	ig in the u	nderlying ca	ause give	on in Part I.		23e. Did to			the cause of death?
Vital Record	The law ate has b page 2 s	Completed	Coronary artery	disease							1 Yes	rmed? 2 No	prior to death?	topsy findings available completion of cause of 2 No
of	ing Physicl . After this ce	ation: To Be	27. Manner of Death 1 Manural 5 Pending 2 Accident investigation	1 Inpati 28a. Date of Inj (Month, Da	ury 28	/Outpatier b. Time or tn i ury		8c. Injury Work	or: 4□ Nu	rsing Ho	(Check only only only only only only only only	dence 6	Other (Spec	cify)
Division	i te	al Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	1	tc."(Specify)				ie, date an	Į.	City or Tow	vn, State)		ral Route Number,
•	To tha Hospital of within 24 hours at To the Funaral D completely filled in	Medical	(Check only 2 ☐ Medical Examone) 29b. Signature and title of certifier	ner: On the basis and manner s	of examination tated.	and/or in	vestigation,	in my op	number	th occurre	ed at the time,	date and p	signed (Month	to the cause(s)
	Sta Regist		31. Date filed (Month, Day, Year) JAN 1 2 2006	ompleted cause of	BVAM trar's Signature	C	10 N	, Gr	eere .	St.	Balthr	nove	MD 2	1207

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 9 per th 9851 1-17-06 vt.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** THOMAS BENJAMIN HERBERT 1 11 2006 12:Noor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1510 Kennewick Road Baltimore NA If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Montese (State of Foreign Days Hours 1 X M 2 □ F Director 051-40-1137 Yrs. 5-8 78 B.W.I. Usual Residence of Decedent lited within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23e or 28e-f show other traumatic avant. The Madical Examiner must be natified at 1X Yes 2 □ No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1510 Kennewick Road 21218 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: West Indies 3

Widowed 4

□ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if itam 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Carpenter 12th grade Carpenter Union 17 2 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anthony Herbert Mary Frances Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Herbert Daughter 1510 Kennewick Rd., Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 5 permit. Page Dep rtment of Important: if any injury or once. Kensico Cem. 1-19-06 Valhalla, N.Y. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 la Wan March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) Sepsis Secondary to Small Bowel Obstruction Wks /Medical Due to (or as a consequence of): Examiner Prostate Cancer Yt. Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Parkinsons Yrs that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Hypertension Physician/Medical Yrs IF FEMALE 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the aid be detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Gout 3 ☐ Probably 4 ☐ Unknown 2 No peeu Cerebialvascular Accidents 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate Glaucoma, Gastroesophageal Reflux 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attanding Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. 2 Accident investigation М 1 ☐ Yes 2 ☐ No completely filled in by the Diractor; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54749 01-12-2006 ly h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Rollingcross Rd, Baltimore, Md. Allen Reilly, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 2 2006

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 0069 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Hill Lucille 7, 2006 January_ 10:40p/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Randalls Town Baltimore Future Care
5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 1927 West Virginia 6. Sex **Funeral** 1 □ M 200 F 79 212-24-8034 Director April Usual Residence of Decedent Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State of Health and Mental Hygiene Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic svent, the Medical Exertirer must be notified at 1 Tyes 2/XNo Director MD Randalls Town Baltimore the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5412 01d Court Rd. 21133 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white white Specify Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Spring Grove 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental unknown Catherine Weatherall ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3 P.O. Box 225 Rock Creek, West VA 25174 <u>Ellen I. Mathis - Guardian</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition rtment of tx Burial 2 ☐ Cremation 3 ☐ Removal from State Ξ Important: If any injury or once. Loudon Park Cemetery Jan. 12, 06 Baltimore City 4 □ Donation 5 □ Other (Specify) permit. Departn 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Servi Licensee 3620 Wilkens Ave. BAltimore, MD 21229 23a. Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician ongeste resulting in death) /Medical Due to (or as a consequence of) Examiner lthrosd e olec Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) use as the burialthe attending physicien Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, QUATROS 2 No 3 Probably 4 Unknown Be Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? page 1 ☐ Yes 2 NO or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the I 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29b. Signature, and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe 12006 125112 h no completed cause of death (Item 23a) (Type, Print) Suite 101 30. Name and address of person crossroado 20 00 32. Registrar's Signature State Registrar

			For State Registrar	State of M		partment of Certificate	of Health and of Death	Mental Hy	/giene	6 (00470
	Physicia	an	1. Decedent's Name (First, Middle, La	/	- / 7 7	77 ~		2. Date of D Month	eath Day	Year	3. Time of Death
	/Medic	al	4. Failly Name (III and in the size of		Dillard Ha			1		006	1:25PM
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	Funeral		5. Social Security Number 6.		e (In yrs. last birthd	ay) If Under 1 \ Months D	Year If Under 24 Hr. Days Hours Min		irth	9. Birthpl	lace (State or Foreign
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Yland	Now Bit		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	r Location				1	Od. Inside City Limits
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36 after	or its	y Fui	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give	No		Cuban, Mexican, Pue No <i>Specify:</i>	πο Hican, etc.)	Specify	k, White, (etc.
^-AmeS Maryland 21215-0036	and Mental Hygiene. Is marked other then "natural", or itame 23a aumatic event. The Madical Examinat must b	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	1954-62	ecedent's Usual C	Occupation		16b. Kind of Bu	W.	hite
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and	ed off) Be	17. Father's Name (First, Middle, Las Milton O. Hall	1)					e, Maiden Sumam : ɛɛ	a)	
A MC	nd Me mark imatic	2	19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Address (S	treet and Number or F	. Ratcl: Rural Route Numl		State, Zip	Code)
D X Page	alth a		Mrs. Roberta M.	. Hall (W	ife) 732	27 Geise	Ave. Edg	emere, M	Maryland	212	19
altimore,	f of He or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [☐Removal from State	comotoni i	sposition (Name crematory or othe	of or place)	Date	20c. Location -	City or To	wn, State
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. 0	a 🖸	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown		5 Other (special			Mor	th	Day Year
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Division of Vital Records,	after d Direct in by	Certification	3 ☐ Suicide 6 ☐ Could not it determined	28e. Place of Inj	ury - At home, farm, c. (Specify)	, street, factory, or	ffice	28f. Location City or To	(Street and Number own, State)	r or Rural	Route Number,
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	1241		30. Name and address of person who	completed cause of c	death (Item 23a) (Type	pe, Print)	037612 vare Priv	0 1 11			
458	Sta	te	31. Date filed (Month, Day, Year)	2 Drash 70 32. Flegistr	200 FIQNI ar's Signature	Min 39	vare Wiv	C, Balti	more M	Da	11251
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			1- State of Maryland / Department of Health State of Maryland / Department of Health State of Dealth State of			iene _{eg.} 006	00471
A.	Physici		1. Decedent's Name (First, Middle, Last) Loretta Katherine Holton	_	2. Date of Deat Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loca SAINT AFNES HOSP, TAL BALTIMO	cation of Death	TOUTHE	4c. County of Dea	
	Funeral Director	Ż:	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U 212-09-8459 88 Yrs. Months Days Ho	Under 24 Hrs. 8 lours Min. 1	Date of Birth Month Day 2-16-19	9. Bi 917 Ma	rthplace (State or Foreign Country) ryland
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036	ours after dee ai', or Iteme Examiner mi	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes ②□No	nic Origin? (Speciflexican, Puerto Ric	rfy Yes or No- ican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
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Maryland	should be filed within and Mental Hygiene. marked other than imatic event, the M	To Be C		Mother's Name (F		Maiden Sumame)	
		1 00000	19a. Informant's Name/Relationship (Type, Print) Terry S. Holton/son 5409 Highview Ro	oad Arbu	itus, M	21227	
Baltimore,	permit. Pages 1 and 2 Department of Heelth a Important: if item 27 is any injury or other tre-		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery		.006 н	20c.Location - City o Baltimore,	MD
Ba	permit Depar impor any ir		21. Sharature of Funeral Sarriog Licens & 22. Name and Address of Funeral Sarriog Funeral 1328 Sulphur	ral Home Spring	, Inc. Rd. Art	outus MD 2	
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8760,	icate be executed physicien and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
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(2)	To the Hospitei or At within 24 hours after of To the Funeral Direct completely filled in by	dicai	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, da 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	late and place, and on, death occurred	nd due to the ca	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
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	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KONIN IF. SCHIGES AND GUY CAM AVEN.	me B	al him	were Man	& lucel 21229
P	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 2 2006				/

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician JANUARY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia Howard Lorien Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. 5, 19 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 21X F 83 Yrs. West Virginia Director 236-30-4090 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthen "naturel", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Maryland Howard Columbia Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6334 Cedar Lane 21044 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2💢 No Specify: δ White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Nurse Hospital Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any july or other traumatic event song: Patrick V. Foley Julia Ann Twohiq 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda Diaz / Daughter 6114 Cedarwood Drive, Columbia, Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National 1/11/2006 Baltimore, Maryland 21. Signature of Funeral Service-Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. ave 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition)

TANCREATIC CARCINOM A Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of): signed by the attending physicien be detached for use as the buria Be Completed by Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetaf death 3 Ectopic pregnancy in the past 12 months' Day Month Year 5 Other (specify) 4☐Pregnant at time of death ivision of Vital Records, P.O. 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 20 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Numbing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 27. Manner Teath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Naturat 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide ro the Hospital 1 Centifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check 29c. License number 29b. Signature and title of certifier "RIVER NECK RO #109 BALTIMORE, MD 7 se of death (Item 23a) (Type, Print) 201, BACK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:05 PM M Forrest G. Houston January 2006 3, /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 3107 Janet Road Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 € M 2 □ F Director 578-38**-**8585 74 Dec 2, 1931 Oklahoma Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or terms 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 3107 Janet Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 salesperson or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be Department of Heelth and Mental Important: If item 27 is marked t enjury or other traumatic ev. 2008. Truman Houston Nona Florence Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3107 Janet Road Silver Spring, MD 20906 Vilma Houston/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rohald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SUPROSIS Physician 0 10ER /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an neral Director: After this certificete has filled in by the funeral director, page 2 autopsy performed 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural Injury 5 Pendina 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of centile 29c. License number 29d. Date signed (Month, Day, Year) 0001836 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13975 Convecticut AVA SILVER SPAIRS MD 20906 MD R obaidse 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene RegistrarAmend item #5 Per FH 8851 1/20/06 of Death Reg. No 2. Date of Death Month 3 Time of Death 1. Decedent's Name (First, Middle, Last Year **Physician** 8:45 am M Trent Holloway 4, Jan. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 11805 Canfield Road Potomac Montgomery 5. Social Security Number 082-39-0839 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 ₩ F Yrs 69 20, 1936 Winston-Salem Director Usual Residence of Decedent 10a. State 10c. City, Town or Location -how 77 is marked other then "natural", or Items 23a or 28a-f ebor traumatic event, the Modical Examinar must be notified at Yes 2 No MD Montgomery Potomac Direct 10e Street and Number 10f Zin Code 10g, Citizen of What Country? 20854 11805 Canfield Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status be filed within 72 hours after de stal Hygiene. de dother then "natural", or Items Black, White, etc. ☐Yes 2X No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black ģ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Educator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f and Mental William J. Trent Viola Magdalene Scales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth 11805 Canfield Road, Potomac, MD 20854 Wendell M. Holloway/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite eny Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/4/06 Beltsville, MD 4 □Donation 5 □ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Avenue Silver Spring, MD 21. Signature of Funeral See MO0382 Stisle Dollemann 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Stage 4 Breast Cancer 6 years /Medical Due to (or as a consequence of): Examiner Chronic Lymphocytic Lea. 2 years Sequentially list conditions, if any, leading to immediate cause. Errie, Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2√2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 🖵 No or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Tes 2 No Certification: To 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation attar death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral I completely filled peli Hospitel 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only To the P 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier 29c. License number D54378 eseven 30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

State Registrar Dr. Cheryl Aylesworth

JAN 1 2

31. Date liled (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Sales of

6410 Rockledge Drive, Rockville, MD

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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itama 23a or 28a-f ahow any injury or other traumatic avant, the Medical Expiritmer must be collined at one.	Be	17. Father's Name Leste:	(First, Middle r Harr	, Last) y He1.			1			18. Moti	her's Nam Adel	e (First, Middle e Ravsl	e, Maide	n Sumame) eller		
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Division of Vital Records, P	Hospital or Attanding Physician: The law requires that the death certificate be 14 hours after death. Funeral Director: After this certificate has been signed by the attending physicis tely filled in by the funeral director, page 2 should be deteched for use as the but	d by Physician/Medical	Part II. Other sign	ificant condi	tions contri	ibuting to deat	h but not res	sulting in the	underlying	cause giv	en in Par	t I.		tobacco	use contribute		e of death? 4 ⊠tÚnknown
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	, Division	-1	1. Decedent's Name (First, Middle, La	nst)							2. Date of De				3. Time of Death
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	Examir	ier	4a. Facility Name (If not institution, give		1		4b. City, T	Town, or	Location of	of Death		4c.	. County of	Death	
					ter "	ast birthday)	Me If Under		If Under	er 24 Hrs	9 Date of Bir		CARRO		(0)-1
н	Funeral Director			1 ☐ M 2 🖾 F	53	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da 9 / 1 7	y, Year)		Count	ace (State or Foreign try) LAND
			Usual Residence of Decedent								9/1/	195	2 1	IAK.	LUAND
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	ith the Marylan or 28a-f show	Funeral Director	MD CARRO 10e, Street and Number	<u> </u>	WI	ESTMI	-					10 . 00		\perp	1 ☐ Yes 2/☐ No
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	ms 23	era	11. Marital Status	12. Was Decedent	Ever in U.S	5. 13.1	Was Decede			gin? (Spe	cify Yes or No		USA 14. Race -	America	an Indian.
9	or Iter	교	1 ☐ Never Married 2X Married	Armed Forces?							cify Yes or No Rican, etc.)		Black, 1	White, e	itc.
21215-0036	within 72 hours after death with the Maryland one. then "natural", or Items 23s or 28s-f show ite Modical Exerting to rest the resilient at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	(2) NO	Ѕреспу:				Specify:	WHI	TE
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B	permit. Departr Importa any inju		XIA								WESTM				
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0.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant ai 9□Unknown	t time of de	ath 5□	Other (spe	icify)					MONUT		Day Year
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u C	Attanding Pher death. actor: After the by the funeral	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		c. Injury Work	?		8d. Describe	how injur	y occurred		
isio	death.	icat	2 Accident investigation 3 Suicide 6 Could not be	OO Dlag of lai	une At hor		M		es 2⊡≀	-	Of Logation /	Ctromt o m	- Al-	a O as /	Carrie Months
Division	To the Hospital or Attani within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification;	4 Homicide determined	28e. Place of Inj building, et	c. (Specify)	ne, rami, str	еет, тастоту,	опісе			City or To	vn, State)	r Hurai	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier 1 Certifying P	hysician: To the best	of my know	vledge, death	occurred a	t the time	e, date and	d place, a	nd due to the	cause(s)	and manne	r as sta	ted.
	ha Ho in 24 ha Fu pletel	Medical	(Check only 2 Medical Exa	miner: On the basis o and manner sta	t examinati	on and/or inv	estigation, i	in my opi	inion, deat	th occurre	d at the time,	date and	place, and	due to	the cause(s)
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			J Boston N						462			Jan	arry	10	, 2006
	1		30. Name and address of person who	0 11 11	leath (Item	1 1 0	1			1	nopun	-	P	∩ → ⊢	r 0
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	Registi	-	JAN 1 2 2	006	ار متا	K A	acule								

State of Maryland / Department of Health and Mental Hygiene For State Registres Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Jackson orraine January /Medical Lorraine Jack 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bathnore UIY

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hospita 1 Baltimore of 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F Months 65 214.38.2756 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f ehow other traumatic event, the Madical Examiner next by notified at Reisterstown Funeral Director Baltimore Maryland

10e. Street and Number 10f. Zip Code 21136 238 11903 larrogon atent Known as "natural", or Items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event, Ite Madic once. Elementary/Secondary (0-12) College (1-4or 5+) Analysis 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (James Blake Nellie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodney W. Jackson
20a. Method of Disposition Tarrogon Rd. Reisterstown, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify Arbutus Memorial Park 21. Signature of Funeral Service I 23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on sa ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician cell Small lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of). physicien Physician/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for 5 Other (specify) signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by peen has 25. Was case reterred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

01:31 AM 11 2006 4c. County of Death Birthplace (State or Foreign Country) Maryland June 22,1940 10d. Inside City Limits 1 ☐ Yes 2 XNo 10g. Citizen of What Country? U.S. A. 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Insurance E. Banks 20c. Location - City or Town, State Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones Funeral Home, P.A. 4611 Park Heights Ave. Baltimore Maryland 21215 Approximate Interval Between Onset and Death year 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 X No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Modical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) January 11,2006

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 1 2 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ami

MD

. Registrar's Signature

Hospitel

the

29c. License number

	1	umend item#17,20a-c,22	perfit (851 State of M	1/23/06 aryland		artment o				giene Reg. No.	006	00479
Physician /Medical Examiner	j	John Johnson a. Facility Name (If not institution, give				4b. City, Tow	vn, or Loc	ation of Death	2. Date of Dea Month	y Day		6 2:55 PM
Funeral Director	47	214-18-82/3		ge (In yrs. las	st birthday) Yrs.	If Under 1 Y		Ore Under 24 Hrs. Durs Min.	8. Date of Birt (Month, Da) Apr 14	h Year)	9. 8 5 Ma	irthplace (State or Foreig Country) ryland
the Maryland		Jsuat Residence of Decedent 10a. State 10b. County MD 10e. Street and Number		10c. City,	Town or Lo	re				10- 614	6 1815 - 4	10d. Inside City Limit:
72 hours after death with the Maryland natural; or items 23s or 28s-1 show are Examiner nata the notified at steel by Funeral Director		6209 Park Height 1. Marital Status 1. Never Married 2	S Avenue 12. Was Decedent Armed Forces? 1 □ Yes 2 ₹ If Yes, Give Year or Dates:	•			21215 of Hispar Cuban, M		ecify Yes or No- Rican, etc.)	. 1	Black, Wh	nerican Indian,
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1 and 1 and 2 mm 2 mm 2 mm 2 mm 2 mm 2 mm 2 mm 2		Ruth Johnson/sis 20a. Method of Disposition 1 Description March Property Propert	Removal from State	20b. Plac	ce of Disponetery, crei	42nd St esition (Name of matory or other	of		Washin	20c. Loc	cation - City o	or Town, State
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To the Hospital or Attendia within 24 hours after death. To the Funerel Director: A completely filled in by the fu Medical Certificatie		29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of examinatio	edge, deat n and/or in	h occurred at the vestigation, in a	ne time, di my opinio	ate and place, n, death occurr	and due to the dred at the time, d	cause(s) date and	and manner a place, and du	as stated. ue to the cause(s)
To th within To th Comp		29b. Signature and title of certifier County 30. Name and address of person who	ylngn completed cause of c	M D	3a) (Type,	AT &		3941	6F13 =	JAN	VARY	nth, Day, Year) 5 200 (
State Registrar		31. Date filed (Month, Day, Year)	32//Registi	rar's Signatur		sele!	, 10	· ioran	riv	-6 ()	NL /-	119 .

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 2:35 PM **Physician** 06 JAMES LEDA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Adelphi George 3210 Powder Mill Rd Hillhaven If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Sept 24, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 ☐ M 2 🂢 F Yrs. 1908 Texas 432-78-8774 97 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show with injury or other traumatic event, the Madical Examiner must be notified an once. 10a. State 1 ☐ Yes 2√ No Prince George's Adelphi Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3210 Powder Mill Road 20783 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white Baltimore, Maryland 21215-0036 Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) teacher education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Keeton Murphy May Viola Daniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9330 Sombersby Court Laurel, MD 20723 Cleo Jackson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature gt-Funeral Service Licensee
Ronald S. Wade, Director

22. Name and Address of Facility
State Anatomy Board 655 W. B.

Baltimore, MD 21201

23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ongestive **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? cate has been signed by the atterpage 2 should be detached for 4 Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to comp death? autopsy 1 Yes certificate 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be examiner' 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 ☐ Residence 6 ☐ Other (Specify) Nursing Home Certification: To 28d. Describe how injury occurred Manner of Death

Natural

Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Redical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and ganger stated. 29a. Certifier Medical (Check only To the 29c. License number 29b. Signature as di title of certifier 140 completed cause of death (Item 23a) (Type, Print) , 1080/ Locku Jood L 2. Registrar's Signature Registrar

ANK -02	A JONSS 36	SON	Pleas	se Type or Prin	nt in Black Ir aryland / Dep			-	•	ble.		0 !
		ľ	1 - For State Registrar	State of Mi		rtificate of L			g. No.	6	JU4	81
	61	4	Decedent's Name (First, Middle,	Last)				Date of Death	1	Voor	3. Time o	Death
	Physici /Medi		lwanka Jonsso					JANUARY	9, 200	06	1315	Рм
	Examir	er	4a. Facility Name (If not institution, RT 40 W/B @ WALI	- :		4b. City, Town, or ABERDEEN	Location of Death		4c. County			
	-				e (In yrs. last birthday		If Under 24 Hrs. A	. Date of Birth	HARF		lace (State (r Foreign
	Funeral Director		213-66-5170	1 M 2 F	81 Yrs.	Months Days	Hours Min.	Month, Day,		Polar	lace (State of try)	n i Greigi
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			134-1		Od. Inside C	in . 1 i in .
	Maryla febo	Į.		1								2X No
	r 28e-	rect	MD Harfo	ora	Aberdeen	10f. Zip Code		10	g. Citizen of	What Coun	try?	
	th with	by Funeral Director	918 Edmund St.			210	01		Polanc	4		
	r deal	uner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.		spanic Origin? (Speci n, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Rac	ce - America ck, White, e		
36	rs afte	y Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	lf Yes 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2√2 No	Specify:		Specif			
21215-0036	within 72 hours after death with the Maryland ane than "natural", or items 23a or 28e-f show the Medical Examination must be notified at	ted	15. Decedent's	Education	16a. Dec	edent's Usual Occupa	ation	1	6b. Kind of B			
218	ithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	life.	B KING OF WORK GONE G DO NOT use retired)	luring most of working)					
	filed with Hygiene. other than		9 17. Father's Name (First, Middle, L	n/a	Hom	emaker	10 Mark and Name (Since Address of the August Au		Hom	e	_
anc	Mental H Merital H arked of attic ever	o Be	Unknown by in				18. Mother's Name (
2 sho and is m		ဥ	19a. Informant's Name/Relationshi		19b. Mai	ing Address (Street a	and Number or Rural I				Code)	
_	e, Mar Tand 2 sho Heelth and In 27 is m		Hans Jonsson,	Jr./Son	3809	Stansbur	y Mill Rd.	. Phoe	nix. M	1D 21	131	
Baltimore, M bearin: Pages 1 and 2 Department of Heelth mportant: if tem 27 i my injury or other tra			20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from State	20b. Place of Disp		Dat	9 2	Oc. Location			
ţ	trent of trant: If it it it or o		4 Donation 5 Other (Sp.	ecity)		Forest V	/et. Cem.		wings	Mills	, MD	
Bal	permit. Pages Department of H important: if its eny injury or of		21. Signature of Properal Service L		1	2. Name and Addres		of Du	lanev	Valle	v. Inc	*:
1	Physician /Medical		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	complications that caused nity one cause on each line. a	the death. Do not er	ter the mode of dying	nia Rd. g, such as cardiac or n	Fimoniu espiratory arre	m, MD	2109	Poroximat Interval Bet Onset and	e ween
	e executed mexment in a line and minial-transit	Examiner	Sequentially list conflicions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	a consequence of):							
68760,	death certificate be executed e attending physicien end id for use as the burial-transit	-	resulting in death) Last	Due to (or as	a consequence of):							
Box	the death certificate be by the attending physici sched for use as the bu	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		¥51		te of delive	,	Year
f Vital Records, P.O. Boysician: The law requires thet the death is certificate has been signed by the atterdirector, page 2 should be detached for u			Part II. Other significant condition	s contributing to death b	ut not resulting in the	underlying cause give	n in Part I.	23e. Did toba	acco use cont		e cause of cably 4 🗀	
		Completed						24a. Was an autopsy perform 1 2 Yes 2	ed?	Were autop prior to con death?	osy findings apletion of c	available ause of
Vital	Physician: this certific al director,	Be	25. Was case referred to medical examiner?	Magaital		l ou	26. Place of Death	Check only one)			
of	E = E	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie			4 Nursing Home	5 Resider			SCEN	E
on	Attending Phyrideath. ector: After thi by the funeral	tlon	1 □ Natural 5 □ Pending ACCident investiga	(Month, Da	Year) Injury	Work	es 2 No	eceaned	pede		un CIO	SSINS
Division	Attendi	ifica	Suicide 6 Could no	ot be 28e. Place of Ini	ury - At home, farm, si	-	70	f. Location (Stre		er or Rural	Route Num	ber,
Ö	rs afte	Certification:	4 - I I MINIOO	building, et	v Cal	C		t Would	State) P+	all	W.B	01
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Cinck only one) 1 ☐ Certifying 27 Medical E	Physician: To the best kandner: On the basis of and manner st	examination and/or it	th occurred at the time restigation, in my op	e date and place, an	d due to the car	use(s) and ma	and due to	ated. the cause(s)
	To the To the Comp	Me	29b. Signature and little of certifier	M	Λ	29c. License			d. Date signe	,		
_				401	1		CIVITE:		CONTRANT	- 10	0001	

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed to the second

cause of death (Item 23a) (Type, Print)

			For State Registrar		State of Ma	ryland / Dep <i>Ce</i>	artment of F			giene 06	00482
	Physici /Medic		1. Decedent's Name (Firs	t, Middle, Last)			7	ONES	2. Date of Dea Month	Day Ye	3. Time of Death
	Examin		4a. Facility Name (If not in	stitution, give	treet and number)		4b. City, Town, o	r Location of Death		4c. County of I	
			The Johns		Lins Hosp	100	Baltin	ore Cit	-y		N/A
7	. Funeral Director		5. Social Security Number 213-30-712	1 [7. Agla	(In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.		v, Year)	Birthplace (State or Foreign Country) Maryland
	and and		Usual Residence of Dece 10a. State 10b.	dent County		10c. City, Town or L	ocation				10d. Inside City Limits
	Marylan f show	to	Maryland	Anne A	rundel		Gle	en Burnie			1 X Yes 2 ☐ No
	r 28a	rec	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	at Country?
	th with	al D	508 Hamlen Re	oad				21061		L	J.S.A.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23c or 28a-f show or other traumatic event, the Marked Event within the Lottliffed at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ □	☐ Married	12. Was Decedent E Armed Forces? 1 Tyes 2 No. If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Black, \ Specify:	American Indian, White, etc. Black
2-0	72 ho	Completed		ecedent's Edu y highest grad			edent's Usual Occup e kind of work done		king	16b. Kind of Busin	ess/Industry
7	ithin 79.	nple	Elementary/Secondary		College (1-4or 5-	life.	DO NOT use retired	d)	All 19	State	Of Maryland
12	filed within Hygiene. thar than "		12	A 6:-dell= - ()			Socia	al Worker	- (5° - 14° 1 "		
Maryland	t be fi	Be	17. Father's Name (First,	міааів, Last) Horace Ві	ackstone			18. Mother's Nan		Maiden Sumame) da Simpson	
Z	should be and Mental is markad c	^C	19a. Informant's Name/R			19h Mail	ing Address (Street	and Number or Ru		er, City or Town, Sta	ate Zin Code)
<u>≅</u>	and 2 seath an n 27 is		Sylvia Warren		p 0, 1 (m)		724 Mayfield			-	10, <i>Lip</i> 0000)
ē,	es 1 and 3 of Health if item 27 rr othar tr		20a. Method of Disposition	n .	-		osition (Name of amatory or other place		Date	20c. Location - Cit	y or Town, State
Baltimore,	Pages nent of H int: If its		1 🔀 Burial 2 🗌 Cre `4 □ Donation 5 🗆 (emoval from State		mmunity Chris		01/14/06	Elkridg	e, Maryland
ati	f Egg		21. Sigurore of Funeral	Service Licens	pre //	The state of the s	22. Name and Addre	ss of Facility			
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- 3			23a. Part1. Enter the dis	ease, or compl re. List only of	cations that caused ne cause on each line	the death. Do not er e.	nter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		IN-	MAGGLER	RAL ME	MORRHA	Mrt.		Onset and Death 4 NAYS
	/Medical Examiner		resulting in death)		Due to (or as a	consequence of):					A A A A A A A A A A A A A A A A A A A
1		<u>_</u>	Sequentially fist condition	15,		consequence of):	MOKE				HOAY
V	ted nsit	Examiner	Sequentially list condition if any, leading to immedi- cause. Enter Underlying Cause (Disease or injury	**************************************	000 10 (01 03 0	consoquence or,					
<u>,</u>	be executed ician and burial-transit	xar	that initiated events resulting in death) Last		Due to (or as a	consequence of):					
8760,	ate be ex hysician the buria	dical			1						
9	iffic g p	led	15.55.44.5								
Box	es that the death certifics igned by the attending pt be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent preg	nant	3c. If yes, outcome of		□Ectopic pregnance	v		23d. Date o	
	e dea he at hed fo	SICI	in the past 12 mont 1 □ Yes 2 □ No 9 □ Unknown	15 ?	4□Pregnant at t		Other (specify)	<u></u>		Month	Day Year
P.0	d by tetach	Phy	Part II. Other significant	conditions co	atributing to death bu	t not reculting in the	underhing cause on	on in Part I	23a Did to	phacca use contribu	ute to the cause of death?
S,	ires ti signe	l by	ATD. SA	. ()	PILLATIO		underlying cause giv	ren in Fanti.			Probably 4 Durknown
Ö	w requir been si should	Completed by	711011	1117	C1001110						
Rec	has ge 2	mpl							24a. Was autop perto	osy prio dea	re autopsy findings available or to completion of cause of th?
Ta	ician: Th certificate rector, pag		25. Was case referred to	medical				26 Place of Doc	1 Yes	0	Yes 2□No
of Vital Records,	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2	To Be	examiner? 1 ☐ Yes 2 ☐ No	T.	lospital:	nt 2 ER/Outpatie	ent 3 DOA Ott		ath <i>(Check only o</i> lome 5 ☐ Resid	dence 6 □Other	(Specify)
101	ding Phys n. After this funeral di	n: T	27. Manner of Death	15	28a. Date of Injury (Month, Day	y 28b. Time		ry at		now injury occurred	
io	Mtandin death. ctor: Aff y the fur	atlo	2 Accident	Pending investigation	(Monan, Say	roas, injury		Yes 2 □ No			
Division	r Atta	Certification:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Inju	ry - At home, farm, s . (Specify)	treet, factory, office		28f. Location (5 City or Tox		or Rural Route Number,
D	a Hospital or Attand 24 hours after deatl a Funaral Diractor: etely filled in by the										
	Hosp 24 hou Funa Funa	edical	29a. Certifier (Check only 2	Certifying Phy Medical Exami	sician: To the best oner: On the basis of	examination and/or i	ith occurred at the til nvestigation, in my o	me, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
	To the Hospital or Attanding within 24 hours after death. To the Euneral Director: After completely filled in by the funer	Med	29b. Signature and title of	i certifiaru	and manner sta	(ed.	29c. Licens	se number		29d. Date signed (#	Month, Day, Year)
	F 3 F 8		100-	usi	M.D.		Doi	7 62 1212			y 10 to 2006
	1		30. Name and address of	/	140	eath (Item 23a) (Tyne	Deleth				
	5		NEMAS	NAVA	,	1 1 1 1	WOLFE	STREET	BALT	IMONE !	MA 21287
	St	ate	31. Date filed (Month, Da	y, Year)	32. Registra	r's Signature			7	7	
	Regist	rar	JAN	1 2 20	06	K	Co.K.				
DH	HMH 17 Rev 1/2	2001				1					
						ORIGIN	AL				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 8, 20ď6 Ivan Klc 1:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5022 Alice Avenue Ellicott City Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) June 17,1962 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Slovakia **Funeral** 1⊠M 2□F 43 Director N/A Yrs. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "neture!", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinar manager. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Completed by Funeral Director Maryland Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5009 Avoca Avenue 21043 Slovakia 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give A Year or Dates: 1 ☐ Yes 2 ☒ No Specify: White 3 ☐ Widowed 4 🂢 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudo1f Klc Olga Gavocova ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5009 Avoca Avenue Ellicott City, MD 21043 Vera Gaspar, Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/11/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee ²² Name and Address of Faculty Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Physician injuries /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the deeth certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ♣ Yes 2 □ No autopsy performed? certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 COther (Specify At SCENE tXXYes 2 No 2 this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred oferater of a motor bike that struge 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 5 Pending Injury death. investigation Director: A d in by the fu 1-8-06 1= 35 1 TYes 2 No fixed object
281. Location (Street and Number or Aural Route Number,
City or Town, State) 50dd Alice AVL 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide Road Ellicott city mD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Example Continuous 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mus O.C.M.E. January 9, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINGLI 111 Penn Street, Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

DEVALEM VERMEDT 06-00253 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a 27 pen/L, 853,3/2/06 TT State of Maryland / Department of Health and Mental Hygiene 16 00484 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Draven Kennedy JANUARY 10, 2006 10:15A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ROSEDALE FRANKLIN SQUARE HOSPITAL 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Oct. 17, 2005 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 24 1X M 2□ F 218-73-7180 Director Maryland Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Mantal Hygiene. Imarked other than "natural", or Items 23a or 28a-f show Imatic event, the Musical Examinator must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6714 Havenoak Road, Apt. A3 21237 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Matthew Patrick Draper Amanda Jean Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Jean Kennedy (Mother) 6714 Havenoak Road, Apt. A3, Baltimore, Md. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. Jan. 13, 2006 Baltimore, Maryland 22. Name and Address of Facility
Bruzdziński Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enterine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or flear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final diseas or condition resulting in death) **Physician** Sudden unexplained death syndrome (SIDS) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 25 Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 X Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA s after death.
I Director: After this id in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. JANUARY 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE MIKE 111 PENN STREET BALTIMORE, MARYLAND 21201

Registrar

JAN 1 2 2006

31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please T

Type or Print in Black Indelible Ink. Ensure All Cop			
State of Maryland / Department of Health and Mental	Hygierie () ()	004	8
Certificate of Death	Reg. No.		

		1 - State Registrar		,	Cei	tificate	of Dea	th		Reg. N	lo.		0 7	00
Physic	e ion	1. Decedent's Name (First, Midd	(le, Last)						2. Date of D		May o c Y	'ear	3. Time o	
/Med		Henrietta			armer						2006		5:30) АМм
Exam	iner	4a. Facility Name (If not institution 101 Chester		ver)				tion of Death			c. County of		1 _	
	gill .	5. Social Security Number		Age (In yrs. I	ast birthday)	If Under 1	tertow Year If Ur	nder 24 Hrs.	8. Date of Bi	rth	Queen .			or Foreign
Funera Directo		119-05-7949 Usual Residence of Decedent	1□M 2√F	88	Yrs.	Months [ays Hou	urs Min.	July 1	ау, Yea 7	1917	New	York	or Foreign
yland Now		10a. State 10b. Count	y	10c. City	, Town or Lo	cation						10	d. Inside (City Limits
Mar B-fet	tor	MD Queer	Anne's	Che	stert	own		•					1 🗌 Ye	s 2X No
or 28	Director	10e. Street and Number				10f. Zip C				-	Citizen of Wh	at Count	ry?	
23a	rai	101 Chester Vi		3. m . l . l . l			620				JSA			
ter de	Funeral	11. Marital Status 1 □ Never Married 2 □ Ma	12. Was Decedorned 1 Tyes 2	es?				xican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black,	White, e		
U36 urs at	b	3 Widowed 4 □ Divorce	If Yes Give	es:		1 □ Yes 2	No Spe	icity:			Specify:	Whi	te	
5-C	Completed	15. Decede (Specify only highe	nt's Education est grade completed)		(Give	dent's Usual (done durina	most of work	king	16b.	Kind of Busin	ness/Indu	ıstry	
within she.	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)		oo NOTuse ck Bro				-	[nvest	man+		
Hygin and		17. Father's Name (First, Middle			500	CK DIO.		lother's Nam	ne (First, Middle				<u> </u>	<u> </u>
Maryland 21215-0036 d 2 should be filed within 72 hours after deeth with the Maryland th and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Exemplest must be notified at	To Be	Julius Haber					(Unavai	ilable)					
Ore, Maryla ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic		19a. Informant's Name/Relation	ship (Type, Print)	0	1				ral Route Numb				Code)	
		Louise Shearer	- Niece	100/ 7				7	stertow	_				
Pages 1 nent of H ant: If ite		20a. Method of Disposition 1 ☐ Burial 2 XCremation		ate C	lace of Dispo emetery, crer	natory or other	er place)	1	Date	20c.	Location - Ci	ty or Tow	n, State	
Baltimore, permit. Pages 1 at Department of Hea Important: If item any injury or othe		4 Donation 5 Other (1.00	Met	ropoli	tan Cr			/06	A1	exandr	ia,	VA	
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100 H		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cau	ised the death							aklanu		Approxima Interval Be	ate
Physician		Immediate Cause (Final disease or condition	•	nous Ce	211 Car	rcinom	a, Thr	oat				6	Onset and Mont	Death ns
/Medica Examine	a 51	resulting in death)	Due to (or	as a consequ	uence of):				-					
*		Sequentially list conditions,	b. Due to (or	as a consequ	ience of):									
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹											
O, exec en an rial-tra		resulting in death) Last	Due to (or	as a consequ	uence of):				-					
68760, ificate be executed physician and as the burial-transit	Medicai													
ing ing		IF FEMALE:	23c. If yes, outco	me of pregna	ncv							1		
BOY Meath ce attend	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birt	h 2 ∏ Fetal	death 3	Ectopic preg Other (spec					23d. Date of Month		y Day	Year
P.O.	Physician	9 Unknown	9□ Unknow	m										
15, P.O. Ires that the de signed by the a	by P	Part II. Other significant condit	ions contributing to dea	th but not resu	ulting in the u	nderlying cau	se given in P	art I.	23e. Did	tobacco	use contribu	ute to the	cause of	death?
w require	ted	Anemia							1 🗆	Yes	2 □ No 3	☐ Proba	bly 4 🛭	Unknown
Hec e law hes b	Completed								24a. Was		24b. We pric	re autop	sy findings pletion of	s available cause of
I VITAI RECONGS, ysician: The law requires t is certificate hes been signe director, page 2 should be o	S	05.11							1 ☐ Yes	XON		th? Yes 2	No C	
ysicial ysicial is certi	e o	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☒ No	Hospital:	nationt 2 🗆	ER/Outpatier	nt 3 DOA	7		th <i>Check only</i> ome 5X Res		6 D0th	(0		
O 분 등 교	1-	27. Manner of Death	28a. Date of		28b. Time o		Injury at Work?	_ Nursing Ho	28d. Describe					
sior andin path. or: Aft	atio	E D / too id on it	tigation	bay rour,	injury	М	1 ☐ Yes	2 □No						
Division of Vita Hospital or Attending Physician: 24 hours after death. Funaral Director: After this certificitely filled in by the funeral director.	Certification:	3 Suicide 6 Could 4 Homicide deten	mined 256. Place 0	f Injury - At ho p, etc. <i>(Specif</i>)	ome, farm, str	eet, factory, o	office		28f. Location City or To	(Street a	and Number	or Rural	Route Nu	m <i>b</i> er,
Division (To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the funer	edicai (29a. Certifier 1 🛣 Certify (Check only one)	ing Physician: To the b i Examiner: On the bas and manne	is of examinat	wledge, deat tion and/or in	h occurred at vestigation, in	the time, dat my opinion,	te and place, death occur	and due to the red at the time	cause , date a	(s) and mann nd place, and	er as sta d due to t	ted. the cause	(s)
To the within 2 To the complet	Me	29b. Signature and title of certific	er				icense num	_		29d. D	ate signed (/	Month, D	ay, Year)	
		1		WD		-	DEI	135			1/4/8	56		
7		30. Name and oddress of person					1	C 1			- 61			
	tata	Frederick De 31. Date filed (Month, Day, Year		660. gistrar's Signa		ch Hil	I Kd.,	, Ches	tertown	, M	D 2162	U		
Regis	tate trar	JAN 1		sees.		inte)								
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem 19b per th g851 1-18-06 vt.
State of Maryland / Department of Health and Mental Hygiene 1 C 1 - For State Registrar 00487 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day te 01/11/2006 11:55 A^{M} /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Montgomery Rockville If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/12/1913 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖔 F 92 075-10-3481 Director Czechoślovakia Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-1 show other traumstic event, the Medical Erach at must be notified at 10d. Inside City Limits XXYes 2 □ No Directo Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20852 6121 Montrose Road Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Completed by Specify: 3XXVidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be be Mordechi Hershkowitz Rachel Elias 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6 Cathy Road Foughkeepsie, NY 12603 item 27 Marvin Klenosky/ Son 20b. Place of Disposition (Name of 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ites
any injury or ott 20c. Location - City or Town, State cometery, cromatory or other place)
Lakeside
Memorial Park 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 01/15/2006 Miami, Florida 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in Alech line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** uec ualo SCHEN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury b Examiner Due to for as a conseduence of The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien a for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown is been signed by the should be detach. Part II. Other significant-conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 10 1 ☐ Yes 1 Yes 2□ No or Attending Physician: 25 Was case referred to medical axaminer? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 virsing Home 5 Residence 6 Other (Specify) V1 ☐ Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this After thi 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the efter death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours e To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Jame and address of person who is impleted cause of death (Item 23a) (Type, Print) ld; Koderlle, MD 6 HUBRULKO 19 Monroso 31. Date filed (Month, Day, Year) 32. Panjstrar's Signature State

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Registrar

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	/Medi Examir		4a. Facility Name (If not institution,			4b. City, T	own, or	Location of De		anuary		nty of Death	1110	
45								nore				NIA		
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	ryland how	_	10a. State 10b. County		10c. City, Town or Lo							10	d. Inside City L	
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	alth an 27 is or trau		For A. Butter	/Daughter						Dun			2122	7_
Baltimore,	ges 1 an t of Heal If item 2 or other		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation	3 □ Bemoval from State	20b. Place of Dispo	sition (Name	of)	Date	200		n · City or Tov	vn, State	
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J	s that (by Ph	Part II. Other significant condition	s contributing to death b	out not resulting in the u	nderlying cau	ise give	n in Part I.		23e. Did tobac	co use co	ontribute to the	cause of deat	h?
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04	4		30. Na e and address of person w	ho completed cause of d	leath (Item 23a) (Type, OSKM AVE	Print)	Bo	Itim	7/0					
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	/Medio		Donald	Joseph			ehr				January	8,	2006	3:45	рм
	Examir	er	4a. Facility Name (If not institution	n, give street and number	ər)				Location of	of Death			c. County of De		
			Hospice of th					nthi		0.111			Anne Aı		
	Funeral Director		5. Social Security Number 216-32-4720 Usual Residence of Decedent	6. Sex 7 1 ☑ M 2 ☐ F	Age (In yrs.	last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Birtl (Month, Day Oct. 22			irthplace (State or F Country) ryland	[‡] oreign
	land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City	Limits
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	r 288	Funeral Director	10e. Street and Number	iore	раті	Tmore	10f. Zip	Code				10g. C	itizen of What (Country?	
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	deat ms	ner	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U	I.S. 13.	Was Deced			gin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - An		
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an	d be antal (ad o	Be c	Karl	Leh							(First, Middle,	ivia iU U i	,	0 5	
Maryland	should be nd Mental markad c	ဥ	19a. Informant's Name/Relations		11	19b Mailin	n Address	(Street a	Paul		Il Route Number	r City		Graf	
Ma	and 2 sealth ar n 27 is sar trau		Anna N. Lehr (W								timore,			Zip Code)	
	Hea tam tam		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of	1				ocation - City of	r Town, State	
30	Pages nent of I int: if it		1 ABurial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (S	3 ☐Removal from Stat	le New	cometery, cren Cathe	dral	ceme Ceme	tery	1/12				Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is markad other than "natural; or items 23a or 28a-f show any injury or othar traumatic avant, the Medical Examiner mast be multical an once.		21. Signature of Funeral Service	The state of the s							ion Park , Baltin	t Fu	neral :	Home	
			23a. Part Inter the disease, or	complications that caus	ed the deat								; FID Z	Approximate	
	Pnysician /Medical Examiner		snock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a 9\10	as a conseq	stem	a				me			Interval Between Onset and Dea	
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.O. Box	that the death certifica ed by the attending ph detached for use as t	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unk <i>n</i> own	2 Feta	Ideath 3	Ectopic pre Other (spe						23d. Date of de Month	elivery Day Yea	.r
Ω.	signed by d be detac		Part II. Other significant condition	ons contributing to death	but not res	ulting in the un	derlying ca	ause give	n in Part I.		23e. Did tot	oacco i	use contribute t	o the cause of deat	h?
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ot	Physician: The la	5	1 Yes 2 No	Hospital: 1 ☐ Inpa 28a. Date of In		ER/Outpatient		-	4 L Nui		ne 5 Reside			ecity) hospi	ce
<u></u>	ding T. After funer	ion	1 Aatural 5 ☐ Pendin	g (Month, L	ay Year)	28b. Time of Injury		Bc. Injury Work			.8d. Describe ho	w inju	y occurred		
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Ξ,	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Certifier 1 🛣 Certifyin	g Physician: To the bes	at of my kno	wledge, death	occurred a	it the time	e, date and	place, a	nd due to the ca	use(s)	and manner a	s stated.	
	ha Ho in 24 ha Fu pletel	edical	(Check only 2 Medical I	Exeminer: On the basis and manner s	or examinal	tion and/or inv	estigation,	in my opi	nion, death	h occurre	ed at the time, da	ate and	place, and du	e to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier					License				9d. Da	e signed (Mon	th, Day, Year)	
•				100	0			D3	553	15.	1	1/	9/06		
	J. M.		30. Name and address of person	who completed cause of	death (Item	23a) (Type, F	Print)		0 :	1					
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	Exami	ner	4a. Facility Name (If not instituti Shady Grove A			,				Location of	f Death			c. County o			
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	72 hours after death with the Maryland hatural', or items 23a or 28a-f show dical Examirer must be notified at	by Funeral Director	11. Marital Status		12. Was Decedent	Ever in t	J.S. 13.			ispanic Orig	in? (Spe	cify Yes or N lican, etc.)		14. Race	Americ	an Indian	,
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Maryland	and A		19a. informant's Name/Relation	ship (Ty	рв, Print)									City or Town, State, Zip Code)			
S	and and n 27 m 27		John Larnick	(So	n)	,				ay, Ga	aithe	ersbur	g, M	D 208	86		
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Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy jury or other traumatic event. Its Medical Examination into the notified at one.		21. Sign to re of Funeral Service	License	Mme	w	22	Name Fra 71(and Addres Incis Broa	G. Oz	og F	uneral hnstow	Hon	ne, Ir PA 159	nc.		
	Physician /Medical Examiner		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a												Approxim Interval B Onset an	Between ad Death	
В		7	Sequentially list conditions,	b	b. PWEUMOWIA											JUS!	
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8760,	icate be executed physicien and s the burial-transit	ilcal Examiner	that initiated events resulting in death) Last		Due to (or as	a conse	quence of):										
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S,	es tha igned I be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part									23e. Did 1	tobacco	co use contribute to the cause of death?		f death?	
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	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely Illied in by the fune	Medical (29a. Certifier 1 Certifyi (Check only one) 1 Medica	ng Phys Examin	ician: To the best er: On the basis o and manner st	r examina	nwledge, death ition and/or inv	ostigatio	d at the tim on, in my op	a date and inion, death	tace, an	d due to the f at the time,	date an) and mann d place, and	or as sta I due to	stad. the cause	r(s)
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10	2		30. Name and address of person	who co	mpleted cause of o		n 23a) (Type,	Print)	3005	AC	- VE	राउर	Ho	7,96	A		
	Sta Registr		31. Date filed (Month, Day, Year	2006	32. Registr	ar's Signa	ature	20									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 8:40 A M January 6 2006 Bonita Lane /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Timonium Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2XXF Yrs. May 12, 219-48-7182 58 Mary land Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County orient: if item 27 is marked other than "neturel", or items 23a or 28a-f show injury or other treumatic event, the Madical Examinar must be mailtied at 1XXYes 2 □ No MD Howard Laurel Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20723 U.S.A. 9125 Gross Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: Maryland 21215-0036 Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within it and Mental Hygiene. It is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) Purchaser's Agent Private 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marian Souder Nick Nicholson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Heelth a ent: if item 27 is 9125 Gross Ave., Laurel Maryland 20723 Gary Lane/Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o importent: if eny injury or once. National Crematory 1/11/2006 Falls Church, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home, Inc 7601 Sandy Spring Road, Laurel Maryland 20707 Well. Approximate Interval Between Onset and Death 23a. Parti-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 📉 No 4☐Pregnant at time of death 5 Other (specify) ete has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2**X** No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division 5 Pending investigation 1 Natural efter death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1/6/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

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	/Medic Examin		Ia. Facility Name (If not institution	e, give street and number)	HOSPITA		LTMC	RE	4c. County of Dea	ath			
	uneral irector		5. Social Security Number 217-26-3992		(In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 11/22/1	9. 8i 921 \	rthplace (State or Foreign country) VIRGINIA			
		· -	Usual Residence of Decedent		10c. City, Town or	Location				10d. Inside City Limits			
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Should May	marked matic e	ĭ	19a. Informant's Name/Relations	hip (Type, Print)	19b. M	ailing Address (Street			ity or Town, State,	Zip Code)			
<u> </u>	s 1 and 2 s f Health ar Item 27 ie other treu		RONNIE TOMLII		20b. Place of Di	56 EDMON sposition (Name of crematory or other pla		INUE, BA	LTIMORE c. Location - City o	Town, State			
altimore,			1 ☐ Burial 2 🖸 Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	METRO	CREMATOR	CONTRACTOR OF THE PARTY OF THE		ATONSVI				
Ball permit	important: any injury once.		21. Signature of the real Service	Licensee	dura		ess of Facility HO BERTY HE		JNERAL /E, BAL				
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Div	after deatl Director: d in by the	Certification:	4 Homicide deten	building, etc		, , , , , , , , , , , , , , , , , , , ,		City or Town, S	State)				
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Toth	within To th comp	M	29b. Signature and title of ceptiti	or R. Cru	Zuy		03035		I. Date signed (Mo				
-	头		30. Name and address of person	who completed cause of d	leath (Hem 23a) (Ty	(pe, Print) Box	03035. Y S ECO	URS He	SOPITA	L			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** JANUARY 07 07:16 AM 2006 /Medical 4b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE / HE JOHNS HOPKING HOSPITAL Date of Birth (Month, Day, Year) 01/02/1958 5. Social Security Number **Funeral** 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 3 F 48 066-56-0692 Yrs. Director NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-fahow traumatic event, the Medical Examiner must be notified at Director MD Kent 1 Tyes 2 No Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6995 Quaker Neck Road 21620 Itema 23a United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 € No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry State of New York and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard K. Empie Emma R. Kniskern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Kevin M. Walsh/Companion Item 27 I 6995 Quaker Neck Road Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 Jan 11 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ō permit. Page Deportment Important: If any injury or poss. Chesapeake Crematory Inc. 2006 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives Retter-MO1443 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovascular **Physician** /Medical Due to (or as a consequence of) Examiner Aortic Schedule list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Hiknown Be Completed pertension 24b. Were autopsy findings available prior to completion of cause of death? certificate hes autopsy cerformed' -stage 2□ No 2 -NO 25. Was case referred to medica 26. Place of Death Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 🗗 No 1 Tes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: , 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide To the Hospital within 24 hours at To the Funeral Completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MO

Registrar

Wolfe

Street, Baltimore, Maryland 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600

North

32 Registrar's Signature

Santosh Ocomen

JAN 1 2 2006

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Kenneth L. Lee 01 07 2006 05:45p^M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Riderwood Village Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 11XM 2□ F Yrs. 544-01-5029 Director 05-20-1916 Minnesota Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f show other treumatic svent, the Medical Experiment was be notified at MDDirector Montgomery Silver Spring 1 Yes 2000 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ö 230 3118 Gracefield Rd. #208 20904 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 1942 1 ⊠Yes 2 ☐ No 1945 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "neturel" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other then any injury or other treumetin. Elementary/Secondary (0-12) College (1-4or 5+) Comptroller Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Albert Lee Edna Florence Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian A. Lee/wife 3118 Gracefield Rd. #208 Silver Spring MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State Chesapeake Crematory 1 4 ☐ Donation 5 ☐ Other (Specify) 01/11/2006 Beltsville MD 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Av Silver Spring MD 20910 21. Signature of Funeral Service Licensee mo1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End Stare Parkinson's Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transil Due to (or as a consequence of): attending physician Records, P.O. Box 68760 Physician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 ☐ Unknown þ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Unknown Completed peed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 Yes 2 No Division of Vital 1 Yes 2 € No fo the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 2 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🙀 Natural 5 Pending investigation I Director: A d in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

101

31. Date filed (Month, Day, Year) JAN 1 2 2006

Name and a r s o erson who complete 3110' gracfield Rd.

ed cause of death (Item 23a) (Type, Print)
Silver Spring MD 20904

Registrar

D0043375

01/09/2006

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	iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23s or 28s-f show or other traumatic svent, the Medical Examinat must be notified at	Funeral Director	106. Street and N	1 1/00	d h === 1	γ Λ	10f. Zip Code	10g	. Citizen of What Co	untry?		
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	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di		29a. Certifier (Check only	1☐ Certifying PI	nysician: To the best of miner: On the basis of	f my knowledge deal	th occurred at the time, date and pla evestigation, in my opinion, death oc	on and due to the	(-)			
	o the ithin 2 o the I	Medical	one) 29b. Signature and		and manner sta	ted.	29c. License number					
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h		-	30. Name and add	ess of person who	completed cause of de	eath (Item 23a) (Type,		Jan	uary 02,	2000		
5	/11		Tasha	ZGreen	seig M.D	111 Per	n Street, Baltim	ore, Maryla	nd 21201			
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State of Maryland / Department of Health and Mental Hygiene 001.96 Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William Ralph Maxwell January AM 11, 2006 4:45 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Oeath 4c. County of Death **Examiner** 5 Norhman Ct. Apt. E Baltimore Essex 8. Oate of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Oays Min. 1⊠M 2□F Months Hours 87 217 07 0663 Nov. 21, 1918 Director Maryland Usual Residence of Decedent the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural; or items 23a or 28e-f shov traumatic event, the Medical Examinar must be notified at Maryland 1 Yes 2 No Baltimore Director Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Norhman Ct. Apt. E 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married 1X Yes 2 No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: WW II 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Oecedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: if item 27 is marked other than any injury or other traumatic aven? Elementary/Secondary (0-12) College (1-4or 5+) Police Detective Baltimore City, Gov. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Eustace Maxwell Lillian Mae Savage 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Robert Maxwell (Son) RD. 3 Box 327K Huntingdon, Pennsylvania 16652 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1/12/2006 ' 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland ^{22. Name and Address of Facility}
Bruzdziński Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21. SignAure of Funeral Service Licensee Page 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Non-small cel 720 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. First Uncertying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Oate of delivery 3 ☐Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. the detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 pe 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate has 1 ☐ Yes Division of Vital 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ဥ 1 ☐ Yes S No 4 ☐ Nursing Home 5 X Hesidence 6 ☐ Other (Specify) this After this funeral of 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending Injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the 29b. Signature and life of certifier 29d. Date signed (Month, Day, Year) 2006 2006/04-D 30. Name and address of person who corpoleted pause of death (Item 23a) (Type, Print) 1650 Orleans St, Ball, MD 21231 ILVO MOPLD 31. Date filed (Month, Day, Year) 32; Registrar's Signature Registra

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ORIGINAL

			for State Registrar	State of M	aryland / Depa	artment of rtificate of			ene 0 0 6	00497
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	Funeral Director		5. Social Security Number 6. Se 220-09-2167 10 Usual Residence of Decedent	x	e (In yrs. last birthday) 98 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y 9 / 1 1 / 1		thplace (State or Foreig ountry) RYLAND
	ahow		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
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Baltimore,	permit. Pages 1 and Department of Health important: If item 27 any injury or other tr once.		21. Skinatury of Free ral Sense Licens	90	22	. Name and Addre	ess of Facility FLI AIN ST., V	ETCHER F	TUNERAL	HOME
	Physician /Medical Examiner price and price an	Examiner	23a. Part1. Enter the disease, or complishock, or heart diture. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that nitiated events resulting in death) Last	Due to (or as a	a consequence of):	herself		r respiratory arrest,		Approximate Interval Between Onset and Death
P.O. Box 68760,	death certificate e ettending phy: id for use as the	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes 2 No 9 □ Unknown	Bc. If yes, outcome of 1 Live birth 4 Pregnant at 1 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of deli	very Day Year
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	witi To Con	Σ	29b. Signature and title of certifier	femo			1705	ì	Date signed (Month,	
	10		30. Name and address of person who com PANSURIYA 31. Date filled (Mosth, Day, Kook)	349 n	unlapu	DR /	Westr	ninstea	F WID	21157
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ORIGINAL

				For State Registrar		Maryland	d / Depa		t of H	lealth a	and M	lental Hygi	ene)	16	0049	8		
				Decedent's Name (First, Middle, Las	t)							2. Date of Death	1		3. Time of I	Death		
	÷.	Physicia		Helen McCall Nichols								January				AM M		
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ST 49Am	30%	Funeral Director		5. Social Security Number 6. Sec. 229-05-8911	x 7 □ M 2∏ F	Age (In yrs. ia 88	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day, Sept 19,	Year) 1917	9. Birth Cou Vir	place (State or Intry) ginia	Foreign		
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0-		a or 2		10e. Street and Number 10f. Zip Code 21234									y. Cilizan	or what cou	iiiu y :			
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Ning	Je,	of Hei	1	20a. Method of Disposition	D	l ca	ace of Dispo	sition (Nan	ne of ther plac	(a)		Date 2	0c. Location	on - City or T	own, State			
7	Ē	Page nent o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 🎇 Donation 5 ☐ Other (Specify		ate				1								
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Myglene. Important: If Item 27 Ie marked other than "natural", or Items any injury or other traumatic event, Ira Madical Examinant once.		21. Signature of Funeral Pervice Licens		ector	St	2.Name an tate <i>A</i> 11timo	Anato	omv B	oard	655 W.	Balti	more s	Street			
				23a Part 1. Enter the disease, or composition of the shock, or heart failure. List only of	olications that can	used the death.	. Do not ent	er the mod	e of dyin	g, such as	cardiac o	or respiratory arre	st,		Approximate Interval Betw	9 V <i>ee</i> n		
	-	Physician		Immediate Cause (Final disease or condition)iseuse			Onset and D	eath eath		
	1	/Medical		resulting in death)	Due to (o	r as a consequ	ence of):		,	17.10-1	7				7			
		Examiner	L	Sequentially list conditions	b													
		ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (o	r as a consequ	ence or):											
		be execut ician and burial-trar	хап	that initiated events resulting in death) Last	c. Due to (o	r as a consequ	ence of):		_							_		
	760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	calE		d													
	687	ificate g phy as the	P G		. u.	-												
	ŏ	n cert endin	In/M	23b. was decedent pregnant	23c. If yes, outco	ome of pregnar th 2 □ Fetal		DEctopic pr	eanancu	,			23d.	Date of deliv	•			
	B.	death	sicia	in the past 12 months? 1 2 Yes 2 XVo		nt at time of de		Other (sp						Month	Day Y	'ear		
	P.O. Box	at the I by the	Physician/M	9 Unknown								20 - 5/41-1						
	Division of Vital Records,	Physician: The law requires that the death certifica t this certificate has been signed by the attending ph ral director, page 2 should be detached for use as th	b	Part II. Other significant conditions co	ontributing to dea	ith but not resu	ilting in the u	nderlying c	ause giv	en in Part i				o 3 Pro	the cause of debably 4	eatn? Hiknown		
	000	e law re has be ge 2 sho	Completed									24a. Was ar autopsy		4b. Were aut	opsy findings a ompletion of ca	available ause of		
	Ä	The ate his page	Com									perform 1 ☐ Yes 2	ed? No	death? 1 ☐ Yes	2 No			
	/ita	cian: ertific ector,	Be (25. Was case referred to medical examiner?	Manaikati				0,11		of Death	(Check only one	9)		- 1/			
	f	shysi this o	7	1 Tes Sino		patient 2 🗆 8	ER/Outpatier			4 🗆 141		me 5 ☐ Reside			ty) HOSPI	Ce		
	n C	Jing f	ion	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of (Month	Day Year)	Injury	M	8c. Injun Worl	yal k? Yes 2. □		28d. Describe ho	w injury oc	curaa				
	isio	death death ctor: y the	licat	2 Accident Investigation 3 Suicide 6 Could not be		of Injury - At hor	me, farm, str					28f. Location (Str	eet and Nu	umber or Rui	al Route Numb	ber.		
	Θ	after Dire	Certification: To	4 Homicide determined	building	g, etc. (Specify,)	,				City or Town	State)					
		To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ledical C	(Check only one) Cartifying Fh. 2 Medical Exam	yelcian. To the b niner: On the bas and manne	is of examinati	wladge, deat ion and/or in	t undurrad vestigation	at the tin , in my o	na, date an pinion, dea	nd plane ath occurr	and due to the ca ed at the time, da	ue (e) and ite and pla	ce, and due	clated to the cause(s)			
		Fo the	Me	29b. Signature and title of certifier				290	. Licens	e number		29	d. Date sig	gned (Month,	, Day, Year)			
		- >F 0		I prom Pla	8 m.)		_ 0	006	1199			Jan,	7, 200	06			
				30. Name and address of person who	completed cause	of death (Item	23a) (Type,	Print)			, ,	12 = ((-					
	jine.			Jason Black, 660	I NOVI	r Chark	255	(4)	504	, MI). 2	120-1						
		Sta Registr		31. Date filed (Month, Day, Year) JAN 1 2 20	06	gistrar's Signat	ргө	ALL										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1**X**M 2□ F 717-40-6814 Usual Residence of Decedent Yrs. Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Iteme 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DQ NOT use retired) 16b. Kind of Business/Industry ing most of working (Specify only highest grade completed) d 2 should be filed within 7: th and Mental Hygiene. 7 Is marked other then "n (0-12) College (1-4or 5+) enouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Pages 1 and 2 should be ment of Health and Mental 19a. Informant's Name/Relationship (Type, Print) Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Itam 27 Method of Disposition Department of Important: If It eny Injury or o Burial 2 Cremation 3 Removal from State Donation _5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee En 23a. Part1. Enter the disease, or complications that ceused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) P.0. be detached 9 Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 1 Yes 2 No 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2. **P** No 2 No 1 Yes 25. Was case referred to examiner? Certification: To Be 26. Place of Death (Check only) 2 10 No Hospital: Other: 1 🗌 Inpatient 1 Tyes 2 ER/Outpatient 4 ☐ Nursing Home 5 esidence 6 ☐ Other (Specify) 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) pletely filled in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 V Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide To the Hospitel 12 Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, 32. State

DHMH 17 Rev 1/2001

Registrar

Physician /Medical Examiner death certificate be executed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-f show any futury or other traumatic event, the Model Examiner qual be notified at ORGE.

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mentai Hygiene. int: If Item 27 is marked other than "natural", or Ite

Baltimore, Maryland 21215-0036

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attending physician and for use as the burial-transit been signed by the should be detached certificate hes t lirector, page 2 s director. SIL After thi funeral I Director: A id in by the fu To the Hospital or At within 24 hours after of To the Funerel Direct

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

death.

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29a Certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Memorial

10061

29c. License number

29d. Date signed (Month, Day, Year) January 8,

30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

31. Date filed (Months Bay Year) gistrar's Signature 32. 2

State Registrar